WELLSTAR Health System

2019 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

Your **Health.** Our **Mission.**

WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill Hospitals

WellStar Cobb Hospital

EIN: 51-0185621
3950 Austell Road, SW
Austell, GA 30106

With 382 beds, WellStar Cobb Hospital offers leading-edge cancer treatment, a state-of-the-art cardiac program, a warm maternity center with private rooms and accredited joint and spine surgery programs.

WellStar Health System, the largest health system in Georgia, provides patients with world-class healthcare close to home, treating the entire family from birth. With 11 hospitals, 2,900 physicians and advanced practitioners on medical staff, 240 medical office locations, outpatient centers, health parks, a pediatric center, nursing centers, hospice and homecare, WellStar is there for your family when and where you need us.

WellStar Douglas Hospital

EIN: 56-2380090
8954 Hospital Drive
Douglasville, GA 30134

Since 1982, this 108-bed hospital has served Douglas County with world-class inpatient and outpatient services, earning recognition as one of the top-ranked Community Value Hospitals in the nation.

WellStar, the largest health system in Georgia, is known nationally for its innovative care models and is focused on improved quality and access to healthcare. WellStar is dedicated to reinvesting back into the community with innovative treatments and state-of-the-art technology and facilities. Our vision is to deliver world-class healthcare.

WellStar Kennestone Hospital

EIN: 58-1245368
677 Church Street
Marietta, GA 30060

This 633-bed community hospital continually earns its distinction as a "Top 100" hospital with ongoing investment in new technologies such as Georgia's first CyberKnife®, TomoTherapy® and da Vinci® robotic surgical systems.

WellStar Kennestone Hospital is known for its "state-of-the-heart" cardiac program, collaborative vascular program, multidisciplinary STAT cancer treatment and renowned Women's Center. And our emergency room (ER) — one of the busiest in the state — includes an accredited chest pain center. No wonder WellStar Kennestone is known as an established healthcare provider for metro Atlanta and its surrounding communities, as well as a tertiary referral hospital within WellStar Health System.

Spanning more than half a century and three generations, WellStar has grown its not-for-profit healthcare system into one of the nation's best. In 1993, our independent community hospitals in northwest Atlanta merged, creating WellStar Health System. Today, WellStar leads the way toward bringing world-class healthcare to Georgia.

WellStar Paulding Hospital

EIN: 05-0578448
2518 Jimmy Lee Smith Parkway
Hiram, GA 30141

A state-of-the-art replacement hospital opened in Hiram in 2014. Today, it features 112 private inpatient rooms, 40 emergency exam and pediatric emergency exam rooms, seven surgical suites, two GI-specific surgical suites, a bronchoscopy suite and decentralized nursing stations.

WellStar Paulding Hospital continues its reputation for high-quality healthcare with an expanding staff of physicians and medical professionals and a connection to additional medical specialties throughout WellStar Health System.

WellStar Windy Hill Hospital

EIN: 20-0164703
2540 Windy Hill Road
Marietta, GA 30067

WellStar Windy Hill Hospital is known for its Long Term Acute Care (LTAC) program, specialized surgical services and interventional radiology expertise, which includes our minimally invasive Center for Fibroid Care. And if you're in need of a good night's sleep, look no further. Our Sleep Disorders Center is nationally acclaimed, with board-certified sleep specialists, a sleep laboratory and the latest advancements in research.

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This report serves to identify and assess the health needs of the community served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. Submitted in fiscal year ended June 30, 2019, to comply with federal tax law requirements set forth in Internal Revenue Code Section 501(r) and to satisfy the requirements set forth in IRS Notice 2011-52 and the Affordable Care Act for hospital facilities owned and operated by an organization described in Code Section 501(c)(3).

A digital copy of this CHNA is publicly available:
www.wellstar.org/chna

Date CHNA adopted by the WellStar board of trustees:
June 6, 2019

Date CHNA made publicly available:
June 30, 2019

Community input is encouraged. Please address CHNA feedback to
chna@wellstar.org

Community Is **Care**

BEING THE BRIDGE

Executive Summary

This report utilizes a data-driven approach to better understand, identify and prioritize the health needs of the community served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals, all of which are not-for-profit hospitals under the Internal Revenue Code (IRC) section 501(r). WellStar Cobb Hospital is a 382-bed facility. WellStar Douglas Hospital is a 108-bed facility. WellStar Kennestone Hospital is a 633-bed facility. WellStar Paulding Hospital is a 112-bed facility. WellStar Windy Hill Hospital is a 115-bed facility. These five WellStar facilities are located within a 26-mile radius and serve the same communities.

Community Health Needs Assessment

The 2010 Affordable Care Act (ACA) requires all not-for-profit hospitals to complete a Community Health Needs Assessment (CHNA) and Implementation Plan every three years to better meet the health needs of under-resourced populations living in the communities they serve. What follows is a comprehensive CHNA that meets industry standards, including Internal Revenue Service regulations set forth in the Additional Requirements for Charitable Hospitals section of IRC 501(r).

WellStar partnered with the Georgia Health Policy Center (GHPC) to complete a comprehensive CHNA process, which includes synthesis of:

The primary focus of data collection for this assessment was on medically under-resourced, high-need and medically underserved populations living in 28 zip codes concentrated in the primary service area of Bartow, Carroll, Cherokee, Cobb, DeKalb, Douglas, Fulton and Paulding counties.

Priority Health Needs

WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals all worked with community and hospital leaders to identify the top community health priorities based on the data included in this assessment.[1]

1 *See the Primary Data and Community Input, Community Health Summit, section of the Appendix for more detailed information about the community health priorities.*

The community health priorities identified for the service area include improving:

1 Access to appropriate care

2 Chronic disease

3 Behavioral health

4 Substance abuse

5 Maternal and child health

Health summit attendees also identified racial and ethnic disparities as a cross-cutting theme and an influencer of each community health priority. As a result, this assessment reports racial and ethnic data where they are available which will inform strategy development.

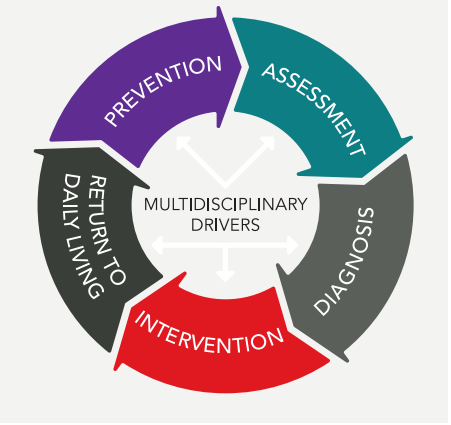
Key Findings

There are specific populations identified in this assessment that experience greater barriers to being healthy, along with higher disease burden and death. This assessment has identified the following populations as the focus of further study and targeted investment to address persistent disparities:

- Black, Latino and Multiracial residents
- Single parents
- Residents from zip codes 30168, 30060, 30008, 30067 and 30106

In general, the communities served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals are younger, higher-income earning and slightly more diverse than the state averages. Cherokee and Cobb counties have larger populations of Hispanic residents, while DeKalb, Douglas and Fulton counties have larger populations of Black residents. DeKalb and Fulton counties also have larger Asian populations. Among the eight counties served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals, Cobb and DeKalb counties have higher populations of residents with limited English-speaking skills when compared to all other counties in the service area.

Figure 1 | Care Continuum



Social Determinants of Health

The communities served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals appear to have significant health needs related to social determinants of health.[2] A closer look at the data by zip code, race, ethnicity and income shows evidence of pockets where the burden of social determinants of health is higher than in the rest of the service area. An example of this is seen in the rate of poverty among single-parent families. While single-parent families experience the highest rates of poverty throughout the service area, Carroll County shows the starkest contrast between single-parent poverty when compared to all other types of families (see Table 3 ARC Income). Another example is seen in Figure 2, where Latino/Hispanic residents are three times more likely, and Black residents are nearly twice as likely, to be in poverty when compared to their White and Asian counterparts.

This assessment also found that many residents do not have access to the most appropriate care to meet their needs due to insurance status, immigration status, the inability to navigate available services, number of providers, quality of care and lack of transportation. Residents have access to appropriate care when there is a properly functioning continuum of care available to them. See Figure 1 for one example of a care continuum.

2 *According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."*

There is evidence in both the secondary and primary data of disruptions in the care continuum throughout the service area. Often, examples of these disruptions are identified through anomalies in data such as:

- Health professional shortage areas
- Hospitalization for preventable issues
- Higher-than-average rates of emergency department (ED) visits
- Higher-than-average mortality rates

These anomalies warrant further investigation to better understand and address the causes.

Health Outcomes

There are several undesirable health outcomes in the service area. Most of the top five causes of death in the service area are related to chronic conditions, lifestyle, behaviors (i.e., heart disease, COPD, lung cancer and stroke) or behavioral health and substance abuse issues. Across the service area, residents of Bartow and Carroll counties have a higher disease burden and death rate. Black and Multiracial residents have the poorest health outcomes (often higher than state rates) when compared to any other racial or ethnic cohort in the service area. These health disparities are most notable in the following conditions:

Health Issues

There are several health issues that are prevalent regardless of race or ethnicity throughout the service area. These include:

Investments in addressing these issues would improve the health of the community served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals.

Data Limitations

There are several limitations to be aware of when considering the CHNA findings:

- Most of the data included in this assessment is available only at the county level. County-level data are an aggregate of large populations and do not always capture or accurately reflect the nuances of health needs. This is particularly important for WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals, because the service area includes Bartow, Carroll, Cherokee, Cobb, DeKalb, Douglas, Fulton and Paulding counties. These counties all contain geographical pockets where residents have higher socioeconomic statuses, as well as much lower morbidity and mortality rates. This juxtaposes areas in these counties that face higher rates of poverty, lower educational attainment and access to care and higher morbidity and mortality rates. Where smaller data points were available (i.e., zip codes), they were included.
- Secondary data are not always available. For example, there is no secondary data source that offers a valid measure of educational awareness in the context of healthy options and availability of resources. In the absence of secondary data, this assessment has noted relevant anecdotal data gathered from residents and stakeholders with lived experience during primary data collection. It is important to note that primary data are limited by individual vocabulary, interpretation and experience.
- There is no measure of the accessibility and effectiveness of available services listed in the Community Facilities, Assets and Resources section of the Appendix, particularly for under- and uninsured residents.

Community Is **Commitment**

WE EXIST TO SERVE

Community Definition

WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals are located in Cobb, Douglas and Paulding counties. The five hospitals are all within a 26-mile radius of each other. For the purposes of this CHNA, the primary service area for the hospitals is defined as the 28 zip codes from which 75 percent of discharged inpatients originated during the previous year. The bulk of these zip codes are located in Cobb County. Additional counties were added by WellStar Community Health Collaborative members to provide a more comprehensive understanding of the geographical region surrounding the primary service area.

The CHNA considers the population of residents living in the 28 residential zip code area regardless of the use of services provided by WellStar or any other provider. More specifically, this assessment focuses on residents in the service area who are medically under-resourced or at risk of poor health outcomes.

Map 1 | Primary Service Area†

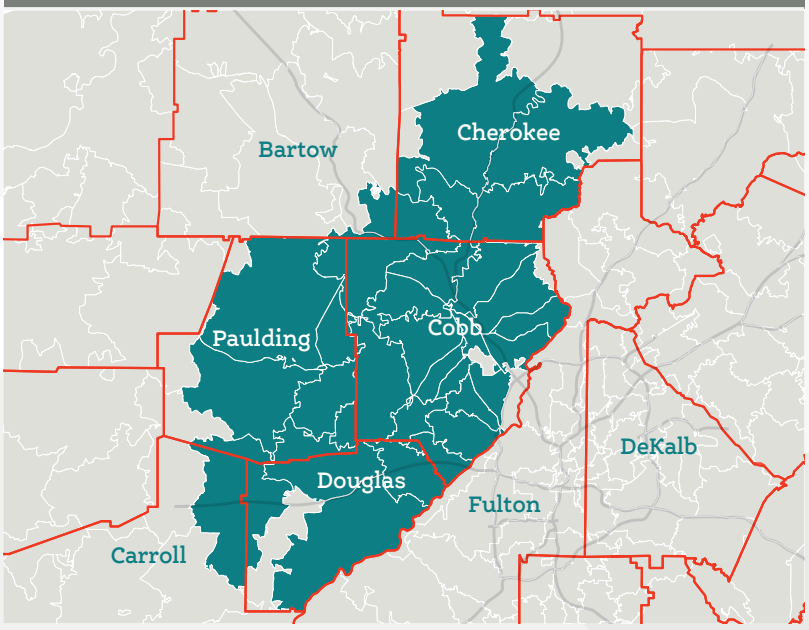


Table 1 | Primary Service Area†

County	Zip Codes (28)	Population (2018)
Carroll	30180	39,917
Cobb	30008, 30060, 30062, 30064, 30066, 30067, 30068, 30080, 30082, 30101, 30106, 30126, 30127, 30144, 30152, 30168	733,002
Cherokee	30102, 30114, 30115, 30188, 30189	244,934
Douglas	30122, 30134, 30135	138,205
Paulding	30132, 30141, 30157	114,186
Bartow		
DeKalb		
Fulton		

† *Truven Health Analytics, Community Needs Index*

Demographic Data

by County and State (2018)*

WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill Hospitals

In general, the communities served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals are younger, higher-income earning and slightly more diverse than the state averages. Cherokee and Cobb counties have larger populations of Hispanic residents, while DeKalb, Douglas and Fulton counties all have larger populations of Black residents. DeKalb and Fulton counties also have larger Asian populations. Among the eight counties served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals, Cobb and DeKalb counties have higher populations of residents with limited English-speaking skills when compared to all other counties in the service area. Hospital and community leaders noted that medical and behavioral healthcare services are not always linguistically relevant for residents who speak a language other than English.

Total Population

US TOTAL POPULATION

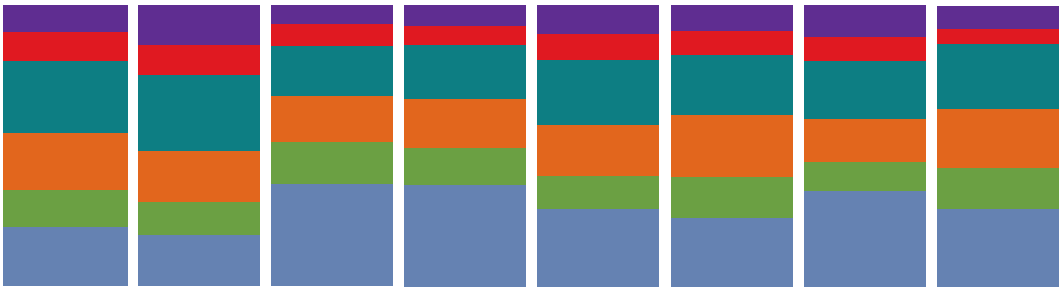
326,533,070

BARTOW	CARROLL	CHEROKEE	COBB	DEKALB	DOUGLAS	FULTON	PAULDING
104,223	138,398	266,801	761,725	820,822	147,264	1,110,620	114,186

Income Distribution (2012-16)

U.S. MEDIAN HOUSEHOLD INCOME

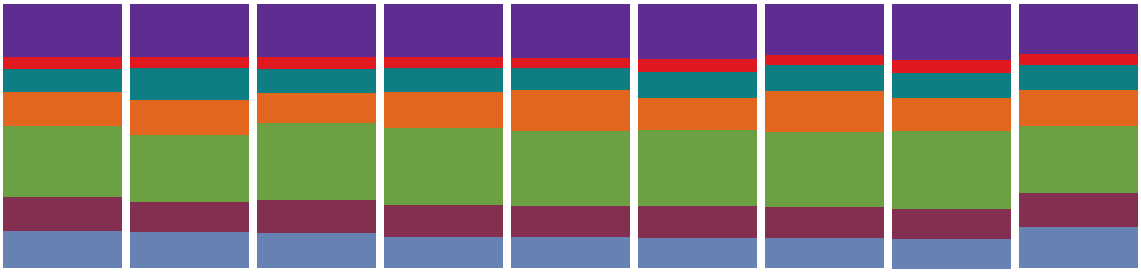
$55,511.00



	BARTOW	CARROLL	CHEROKEE	COBB	DEKALB	DOUGLAS	FULTON	PAULDING
Median household income (2012-16)	$50,565	$45,486	$72,586	$68,818	$52,623	$57,384	$58,851	$60,971
Less than $15,000	9.30%	14.00%	6.70%	7.20%	10.20%	9.20%	11.10%	8.20%
$15,000 - $24,999	10.30%	10.80%	7.80%	6.80%	9.00%	8.50%	8.60%	5.60%
$25,000 - $49,999	25.90%	26.80%	17.70%	19.40%	23.40%	21.40%	20.60%	23.10%
$50,000 - $74,999	20.10%	18.50%	16.50%	17.20%	18.00%	22.00%	15.40%	20.90%
$75,000 - $99,999	13.30%	11.70%	15.00%	13.40%	11.80%	14.60%	10.60%	14.70%
$100,000 and over	21.10%	18.20%	36.40%	36.00%	27.60%	24.30%	33.80%	27.40%

* *Truven Health Analytics, Community Need Index Demographics Expert 2.7, 2018 Demographic Snapshot*
U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: www.census.gov/programs-surveys/acs/

Age Distribution



	BARTOW	CARROLL	CHEROKEE	COBB	DEKALB	DOUGLAS	FULTON	PAULDING	U.S.
Median age in years (2012-16)	37.40	34.10	37.70	36.20	35.20	36.10	35.00	35.40	38.1
0-14 (2018)	20.00%	19.70%	20.00%	19.90%	20.40%	20.60%	19.00%	21.00%	18.70%
Change 2018-23	-1.10%	-1.10%	-1.70%	-1.10%	-0.30%	-1.90%	-0.80%	-2.20%	-18.70%
15-17 (2018)	4.40%	4.30%	4.50%	4.10%	3.60%	4.80%	3.90%	4.80%	3.90%
Change 2018-23	0.00%	-0.10%	0.00%	+0.10%	+0.30%	-0.20%	+0.10%	0.00%	-3.90%
18-24 (2018)	9.10%	12.30%	9.10%	9.30%	8.50%	10.00%	10.10%	9.60%	9.70%
Change 2018-23	+0.40%	-0.80%	+0.90%	+0.20%	0.00%	+0.30%	-0.20%	+0.70%	-9.70%
25-34 (2018)	12.60%	13.40%	11.60%	13.70%	15.60%	12.40%	15.30%	12.60%	13.40%
Change 2018-23	-0.20%	+0.80%	-0.10%	-1.20%	-2.40%	0.60%	-1.70%	-0.20%	-13.40%
35-54 (2018)	26.90%	25.10%	28.70%	28.80%	28.30%	28.60%	28.50%	29.50%	25.50%
Change 2018-23	-1.70%	-0.90%	-2.40%	-1.20%	-0.20%	-2.40%	-0.30%	-2.10%	-25.50%
55-64 (2018)	12.70%	11.50%	12.70%	12.20%	11.80%	12.10%	11.60%	11.50%	12.90%
Change 2018-23	+0.50%	+0.20%	+0.90%	+0.70%	+0.30%	+1.10%	+0.80%	1.50%	-12.90%
65+ (2018)	14.30%	13.60%	13.50%	12.00%	11.70%	11.50%	11.60%	11.20%	15.90%
Change 2018-23	+0.40%	-0.80%	+0.90%	+0.20%	0.00%	+2.40%	-0.20%	+0.70%	-15.90%

Racial/Ethnic Distribution

	BARTOW	CARROLL	CHEROKEE	COBB	DEKALB	DOUGLAS	FULTON	PAULDING	U.S.
White	77.70%	70.40%	77.90%	50.80%	29.40%	43.30%	39.70%	72.50%	60.40%
Black	10.70%	19.30%	7.10%	27.60%	52.10%	43.20%	42.10%	17.70%	12.40%
Hispanic‡	8.50%	6.70%	10.50%	13.20%	9.40%	9.00%	7.60%	6.30%	18.20%
Asian and P.I.	1.00%	1.20%	2.10%	5.40%	6.60%	1.60%	8.10%	1.10%	5.80%
Limited English	2.90%	2.70%	5.20%	7.60%	9.00%	4.50%	5.60%	1.80%	10.00%

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Community Is **Contribution**

ASSESSING THE NEEDS

Data Collection

The Georgia Health Policy Center (GHPC) partnered with WellStar to implement a collaborative and comprehensive CHNA process.

The secondary data included in this assessment are from a variety of sources that are both reliable and representative of the community served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. Data sources include, but are not limited to:

- Centers for Disease Control and Prevention,
- Community Commons,
- Community Needs Index,
- County Health Rankings and Roadmaps,
- Georgia Department of Public Health,
- Georgia Prevention Project and
- U.S. Census Bureau.

Many of the publicly available data sources are only available at the county level, not in smaller segments. However, where possible, the data was analyzed at the zip code or census tract level to get a more comprehensive understanding of the needs in the community. Data sources reviewed for this assessment can be found in the associated data tables.

To better understand the experience and needs of the residents living in the areas served by the hospitals, several types of qualitative data were used, including focus groups with residents, one-on-one interviews with key stakeholders, a listening session with the WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals' Regional Health Boards and a Health Summit with hospital and community leaders. An in-depth description of the participants, methods used and collection period for each qualitative process is in the Primary Data and Community Input section of the Appendix.

Community Is **Connection**

YOUR STORY IS OUR STORY

Health Needs of the Community

Understanding the health of a community and what residents need to be healthier requires consideration of a variety of factors. According to the World Health Organization, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[3]

This assessment includes a consideration of the following factors from the perspectives of community and hospital leaders, residents and secondary data:

- Social determinants of health
- Access to and use of appropriate care
- Health behaviors
- Health outcomes

Community health can be measured in many ways. Understanding how residents feel (morbidity) and what is causing death (mortality) in a community is often a good place to begin when assessing the health of a community. The County Health Rankings, a popular annual measure of county-level health indicators, offers a measure of health outcomes by county. County Health Rankings health outcomes measures length of life and quality of life. Among the counties served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals, Carroll County generally shows the poorest rankings. Bartow and Carroll counties consistently rank in the lower quartiles, which represents the worse mortality and morbidity measures when compared to counties throughout the state. Cherokee, Cobb, DeKalb, Fulton and Paulding counties generally rank in the upper quartiles, which represents the best mortality and morbidity measures when compared to counties throughout the state.

Table 2 | County Health Rankings by County (2018)*†

	Health Outcomes	Health Factors	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Bartow	42	51	60	31	72	54	44	115
Carroll	74	72	93	62	104	55	49	151
Cherokee	3	6	4	3	6	28	5	148
Cobb	7	5	6	11	2	22	8	82
DeKalb	18	24	15	28	12	8	64	103
Douglas	26	36	22	44	41	73	26	117
Fulton	14	19	19	19	10	3	66	95
Paulding	9	14	11	9	15	53	10	84

* *There are 159 counties in Georgia. According to America's Health Rankings, in 2018 the state of Georgia is ranked 39th when compared to other states: www.americashealthrankings.org/explore/annual/state/GA*

† *County Health Rankings and Roadmaps: countyhealthrankings.org*

The leading causes of death in the hospitals' service area are similar when compared to those in the state. The top cause of death in both the service area and throughout the state is coronary artery disease.[4] The remainder of the top causes of death are COPD (except asthma), lung cancer, cerebrovascular disease (stroke) and mental and behavioral health disorders.[5]

3 *World Health Organization, Constitution of WHO: principles, http://www.who.int/about/mission/en/*

4 *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

5 *See the Secondary Data section of the Appendix for a ranked list of causes of death in Georgia*

Social Determinants of Health

According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks." While poverty is not pervasive in the service area, this assessment offers evidence of populations with high socioeconomic barriers to being healthy.

Community input cited a lack of economic security in some areas, poor employment options and homelessness as existing health needs in the community served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. Additionally, secondary data shows high socioeconomic barriers to being healthy in Cobb and Douglas counties. During key informant interviews, community leaders noted areas where families do not have legal immigration status and where there are high rates for unemployment, poverty and uninsured, specifically in areas of Cherokee County – Canton and Woodstock (30115 and 30188); Cobb County – Acworth (30102 and 30120), Austell (30168) and Marietta (30060); and Paulding County – Dallas (30132).

Unemployment has decreased across the area in the last 10 years. During the same period, the median household incomes increased in every county in the service area.[6]

Over the last decade, poverty in the general population has increased in the service area (change ranged between 1.8 percent and 5.1 percent). Single-parent families have experienced the highest rates of poverty. Poverty among this population has increased in every county in the service area except Bartow and Carroll counties. This trend also is found in zip code-level data (see Table 3). Single-parent families in Douglas and Paulding counties saw the greatest increase in poverty during the last 10 years, when compared to the rest of the service area.

6 *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

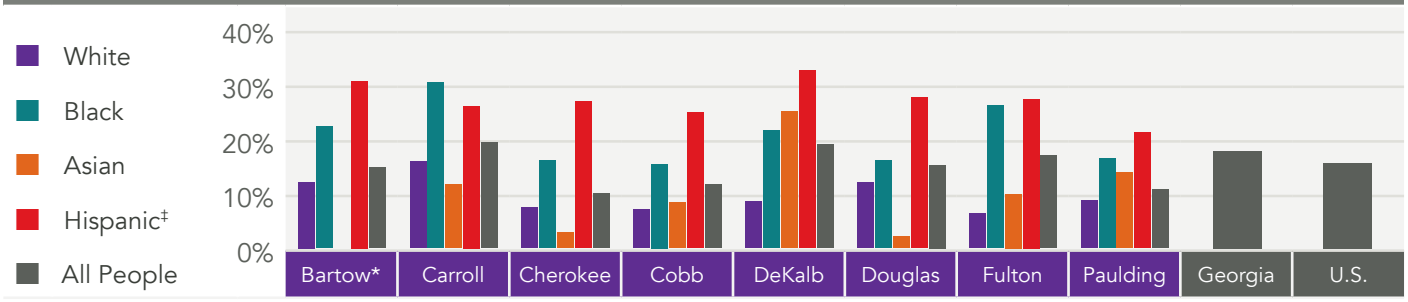
Table 3 | Population Below the Federal Poverty Level by Family Status and County (2006-2015)†

	Bartow	Carroll	Cherokee	Cobb	DeKalb	Douglas	Fulton	Paulding
Total Households								
2006-10	34,301	39,421	74,339	256,741	264,837	44,747	357,463	46,440
2011-15	35,732	40,074	79,133	268,616	267,396	47,079	379,957	49,110
All people								
2006-10	14.00%	17.30%	7.40%	10.60%	16.10%	11.30%	15.30%	8.20%
2011-15	15.80%	20.70%	10.80%	12.40%	19.30%	16.40%	17.60%	12.60%
All families								
2006-10	10.80%	12.50%	5.50%	7.60%	12.40%	8.80%	12.00%	7.00%
2011-15	12.00%	14.80%	8.50%	9.40%	15.00%	13.90%	13.00%	10.50%
Married couple families								
2006-10	5.60%	6.10%	3.80%	3.50%	5.50%	4.20%	3.60%	4.00%
2011-15	6.70%	8.20%	5.10%	5.20%	8.00%	6.70%	4.40%	6.30%
Single female head of household families								
2006-10	32.40%	37.90%	15.80%	22.10%	25.30%	21.00%	31.80%	17.80%
2011-15	31.70%	36.80%	24.90%	23.00%	28.80%	30.80%	33.20%	28.30%

† *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles*

Figures 2 and 3 show the disparities in the poverty and education rates of various racial and ethnic communities throughout the service area, with Latino and Black residents showing the highest rates of poverty and Black, Asian and Hispanic residents showing the lowest rates of educational attainment when compared to their White counterparts. Latino/Hispanic residents are three times more likely, and Black residents are nearly twice as likely, to be in poverty when compared to their White and Asian counterparts. Latino/Hispanic residents are more than four times more likely not to have a high school diploma when compared to their White and Asian counterparts. Black and Asian residents are twice as likely not to have a high school diploma. Carroll County has the highest rate of poverty and residents without a high school diploma. Community input suggests that the state of health in communities served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals has improved for populations with increased employment opportunities and wage growth and declined sharply for populations that are unemployed and experiencing poverty.

Figure 2 | Population Below Federal Poverty Level by Race/Ethnicity and County (2012-2016)†

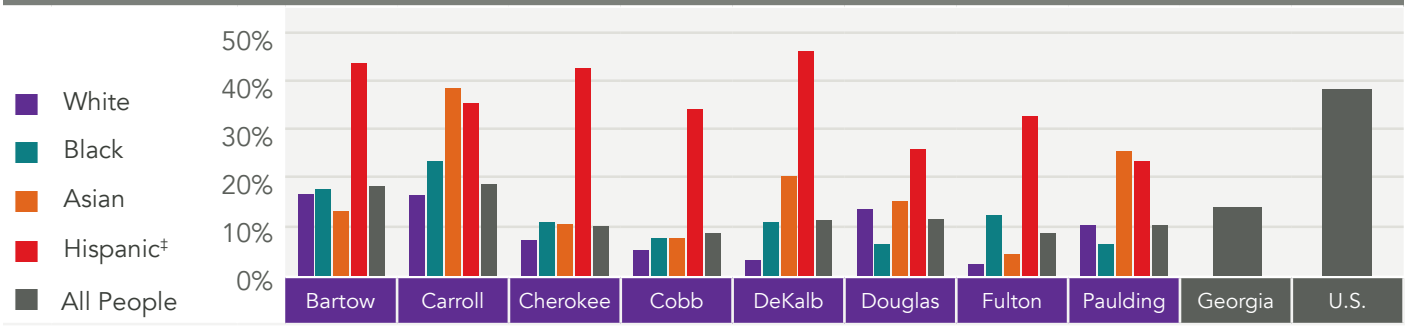


† *U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: http://www.census.gov/acs/www/*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

* *0.00% can result from sample size and margin of error.*

Figure 3 | Percentage of Population Without a High School Diploma by Race/Ethnicity and County (2012-2016)†



† *U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Housing

The quality, age, availability and affordability of housing influence the health of residents in the community. Community input suggests that homelessness is increasing and there are transient tent cities where homeless people are living throughout the service area.

In the last 10 years, home values and homeownership have declined with home ownership replaced by renting. This fact alone does not indicate health challenges and is likely related to both the housing crisis and the younger median age of the service area.

Community input suggests that the rising cost of housing is becoming unaffordable for some residents. One resident described the difficulty seniors experience paying rent on a fixed income:

> "I'm looking at these apartments they're building…one bedroom was $1,200. If you're on a fixed income, you're getting Social Security or SSI, you can't afford to pay $1,200. We have nowhere to go."

Table 4 shows that approximately 30.2 percent of households throughout the service area spend more than 30 percent of their income on mortgages, while approximately 50.5 percent of households spend more than 30 percent of their income on rent each month. Both of these rates have decreased across the service area, with the exception of the percentage of income paid for rent in DeKalb, Douglas and Paulding counties.

Table 4 | Selected Housing Indicators by County (2006-2015)†

	Bartow	Carroll	Cherokee	Cobb	DeKalb	Douglas	Fulton	Paulding
Total households								
2006-10	34,301	39,421	74,339	256,741	264,837	44,747	357,463	46,440
2011-15	35,732	40,074	79,133	268,616	267,396	47,079	379,957	49,110
Family households								
2006-10	75.70%	70.90%	76.80%	67.80%	58.90%	73.80%	56.00%	79.30%
2011-15	72.70%	67.90%	74.80%	68.20%	58.50%	73.30%	54.60%	79.60%
Nonfamily households								
2006-10	24.30%	29.10%	23.20%	32.20%	41.10%	26.20%	44.00%	20.70%
2011-15	27.30%	32.10%	25.20%	31.80%	41.50%	26.70%	45.40%	20.40%
Vacant housing units								
2006-10	11.80%	11.30%	7.30%	9.30%	12.30%	11.00%	16.90%	7.90%
2011-15	10.30%	10.30%	6.50%	7.70%	12.70%	9.10%	14.60%	7.20%
Homes more than 20 years old								
2006-10	55.50%	54.70%	36.60%	59.10%	69.30%	45.90%	61.40%	32.30%
2011-15	74.90%	71.30%	60.60%	79.50%	80.70%	65.10%	73.50%	54.10%
Median value of homes								
2006-10	$146,800	$139,900	$2,019,000	$211,000	$190,000	$157,300	$253,100	$149,600
2011-15	$123,800	$112,100	$190,500	$197,400	$163,000	$121,300	$241,300	$133,500
Households paying more than 30% of income for monthly mortgage								
2006-10	33.90%	34.20%	37.50%	33.30%	40.20%	39.90%	37.20%	32.30%
2011-15	30.50%	31.20%	28.60%	26.50%	35.00%	31.30%	31.70%	27.40%
Households paying more than 30% of income for monthly rent								
2006-10	58.40%	55.40%	49.90%	49.60%	53.70%	48.70%	50.60%	49.70%
2011-15	44.90%	52.20%	48.20%	49.20%	54.10%	51.90%	50.40%	53.00%

† *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

Zip-code-level data shows that many of the zip codes served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals have below average socioeconomic barriers (see Table 5 for Community Need Index [CNI] data in selected zip code areas). A closer look at the data shows geographic pockets in Cobb County where educational attainment and language skills are low and unemployment and poverty are high, specifically in the 30168, 30060 and 30008 zip codes:

- Poverty is high, with more than 40 percent of single-parent families in poverty
- More than one in 10 residents have limited English-speaking skills
- More than 20 percent of residents have no high school diploma

There are existing resources throughout the service area that address the social determinants of health.[7] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the social determinants of health noted in the CHNA.

7 *See the Community Facilities, Assets and Resources section of the Appendix for a list of resources.*

Access to Appropriate Care

Having access to the right care at the right time influences health outcomes as well as healthcare-seeking behavior, according to the input provided by residents and community leaders. Community Health Summit participants identified access to appropriate care as one of the top community health priorities to address. Often, there are a variety of factors associated with the access residents have to appropriate care, such as insurance status, legal status, residents' ability to navigate available services, number of providers, quality of care and transportation.

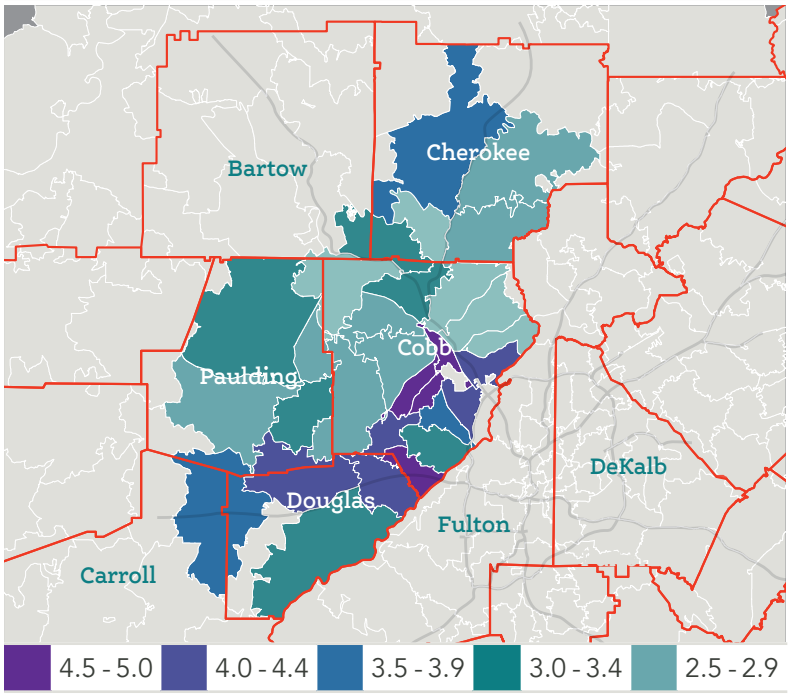
Input from community residents noted that the safety-net services that are available are not culturally and linguistically relevant to meet the needs of all residents. One example is the limited access the residents without legal immigration status have to any form of healthcare.

Community leaders noted that undocumented women are showing up in the ED in labor without ever having had prenatal care due to a lack of insurance and fear of deportation.

Socioeconomic Factors

The CNI ranks each zip code in the United States against all other zip codes on five socioeconomic factors that are barriers to accessing healthcare: income, culture, education, insurance and housing.[8] Each factor is rated on a scale of one to five (one indicates the lowest barrier to accessing healthcare and five indicates the most significant). A score of three is the median for the scale.

Map 2 | 2018 CNI Scores by Zip Code†



This Community Health Needs Assessment for WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals includes 2018 CNI data for 28 zip codes. Over the past year, nine zip codes showed improvement in overall CNI score, while five zip codes showed a worse overall CNI score.

Map 2 and Table 5 depict the 2018 CNI scores for the WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals' service area. According to the 2018 CNI, one-half of the zip codes served by the hospitals have below average socioeconomic barriers to accessing healthcare. A closer look shows:

- The zip codes with the highest CNI scores were 30168 and 30060 (4.8), both of which are in Cobb County.
- 39 percent of zip code areas show barriers that are lower than median for the scale.

8 See the Secondary Data section of the Appendix for complete CNI data.

- Half of the primary counties covered in this assessment showed a decrease in barriers — Carroll (–0.1), DeKalb (–0.1), Douglas (–0.1) and Paulding (–0.2) — while all others remained the same.
- Five zip codes showed increases in the barriers to accessing healthcare between 2017 and 2018.[9]
- Nine zip codes showed decreases in the barriers to accessing healthcare between 2017 and 2018.[10]

Each factor is rated on a scale of one to five (one indicates the lowest barrier to accessing healthcare and five indicates the most significant).

Table 5 | 2018 Community Need Index (CNI): 5 Highest Barrier vs. 5 Lowest Barrier Zip Codes†

Geography		Scores		Income			Culture		Education	Insurance		Housing
Zip	County	Change (2017-18)	2018 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/Kids	LES	Minority	No High School Diploma	Unemployed	Uninsured	Renting
5 Areas With the Highest CNI Scores												
30060	Cobb	0.0	4.8	11%	32%	48%	16%	70%	27%	9%	19%	53%
30168	Cobb	0.2	4.8	16%	32%	44%	9%	89%	22%	11%	20%	51%
30008	Cobb	-0.2	4.6	9%	28%	41%	10%	78%	23%	10%	18%	44%
30067	Cobb	0.2	4.4	8%	22%	46%	7%	57%	9%	7%	15%	59%
30106	Cobb	0.0	4.2	13%	26%	39%	3%	73%	12%	8%	16%	37%
5 Areas With the Lowest CNI Scores												
30062	Cobb	0.0	2.4	5%	5%	20%	4%	33%	6%	4%	7%	20%
30066	Cobb	0.0	2.4	6%	7%	18%	2%	32%	4%	5%	7%	20%
30101	Cobb	-0.2	2.4	7%	8%	18%	2%	33%	7%	6%	8%	18%
30189	Cherokee	0.0	2.4	5%	10%	14%	4%	21%	6%	4%	9%	21%
30068	Cobb	0.0	2.2	5%	5%	18%	2%	24%	3%	5%	6%	18%
Carroll Total		**-0.1**	**4.0**	**13%**	**22%**	**47%**	**1%**	**30%**	**17%**	**10%**	**18%**	**31%**
DeKalb Total		**-0.1**	**3.9**	**13%**	**21%**	**35%**	**6%**	**71%**	**12%**	**9%**	**15%**	**43%**
Bartow Total		**0.1**	**3.8**	**10%**	**17%**	**43%**	**2%**	**22%**	**17%**	**5%**	**12%**	**30%**
Fulton Total		**0.0**	**3.6**	**12%**	**19%**	**35%**	**2%**	**60%**	**9%**	**8%**	**16%**	**45%**
Douglas Total		**-0.1**	**3.6**	**9%**	**17%**	**33%**	**2%**	**57%**	**11%**	**9%**	**14%**	**28%**
Cobb Total		**0.0**	**3.2**	**9%**	**13%**	**25%**	**5%**	**49%**	**10%**	**6%**	**10%**	**32%**
Paulding Total		**-0.2**	**3.0**	**15%**	**10%**	**28%**	**1%**	**28%**	**10%**	**5%**	**9%**	**20%**
Cherokee Total		**0.0**	**2.9**	**8%**	**12%**	**32%**	**3%**	**22%**	**9%**	**5%**	**10%**	**21%**

† *Truven Health Analytics, Community Needs Index (2018)*

9 *Increases in CNI scores between 2017-18: Cobb (30062 and 30066) and Fulton (30004, 30022, 30075, 30328 and 30350).*

10 *Increases in CNI scores between 2017-18: Forsyth (30028), Fulton (30005, 30350, and 30075), and Gwinnett (30092)*

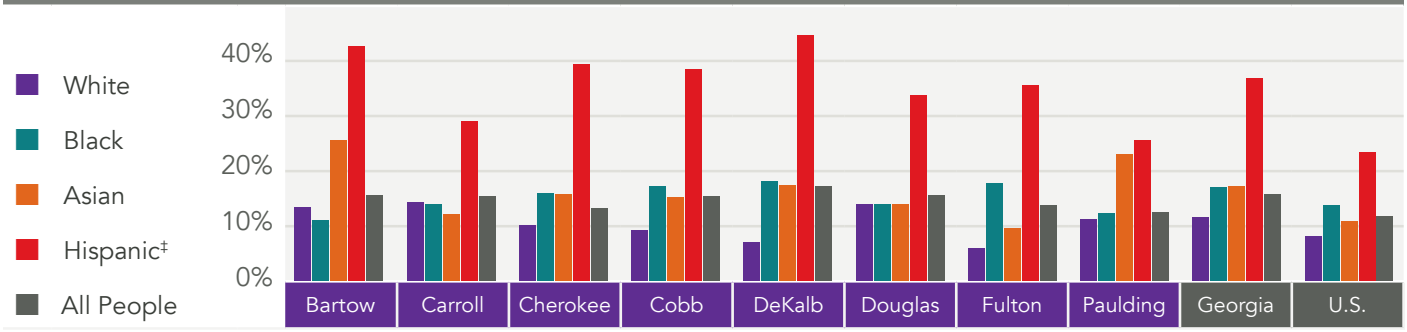
Uninsured

A greater percentage of Georgia residents are uninsured than the national average due to the lack of Medicaid expansion. The percentage of uninsured residents in Carroll and Fulton counties is higher than the state average when considering the general population. One resident recounted her experience being uninsured:

> "It took two years for me to get a diagnosis because those first two years I didn't have insurance. As soon as I got insurance, the next month I got diagnosed and started treatment."

Figure 4 shows the disparities in the rates of uninsured when considering the data by racial and ethnic groups throughout the service area, with Latino and Black residents showing the highest rates of uninsured when compared to their White counterparts; differences in uninsured rates between Black and Asian residents were not drastic. White residents in Bartow and Carroll counties had uninsured rates higher than Black residents. Latino/Hispanic residents are three times more likely to be uninsured, while Black and Asian residents are more than twice as likely, when compared to their White counterparts.

Figure 4 | Percentage of Uninsured Population by Race/Ethnicity and County (2012-2016)†



† *U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: http://www.census.gov/acs/www/*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

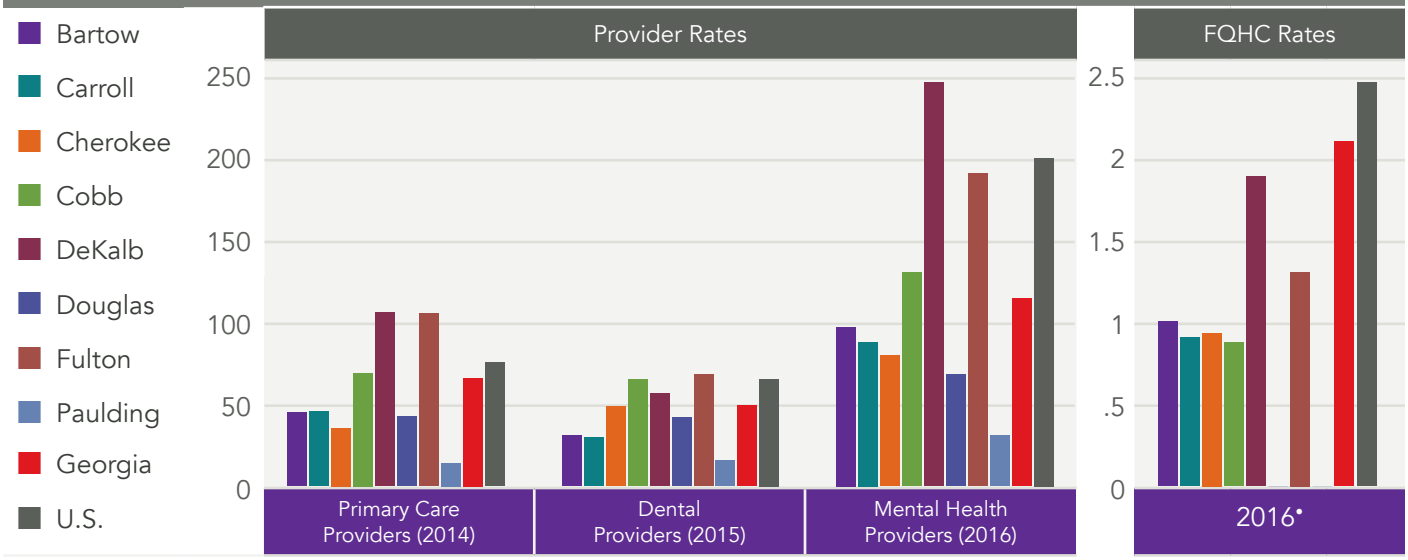
Provider Shortage

There is a shortage of healthcare and dental providers throughout the community, particularly among safety-net providers offering free or reduced-cost care based on income (see Map 3 for a geographic representation). Paulding County has the fewest primary care providers, dental care providers and mental health providers in the service area. Regional board members, Health Summit attendees and community stakeholders discussed the need to increase safety-net services for adults and children. Cobb, DeKalb and Fulton counties have the highest rates of providers when compared to the service area and the state; however, Federally Qualified Health Centers (FQHCs) throughout the service area are below the state and national rates.

One resident described the influence unaffordable dental care had on her family:

> "I'm paying thousands of dollars for my son's teeth right now. My son took his own braces off. Took the brackets off with a spoon. Googled it on YouTube."

Figure 5 | Provider Rates by County Per 100,000 Population†



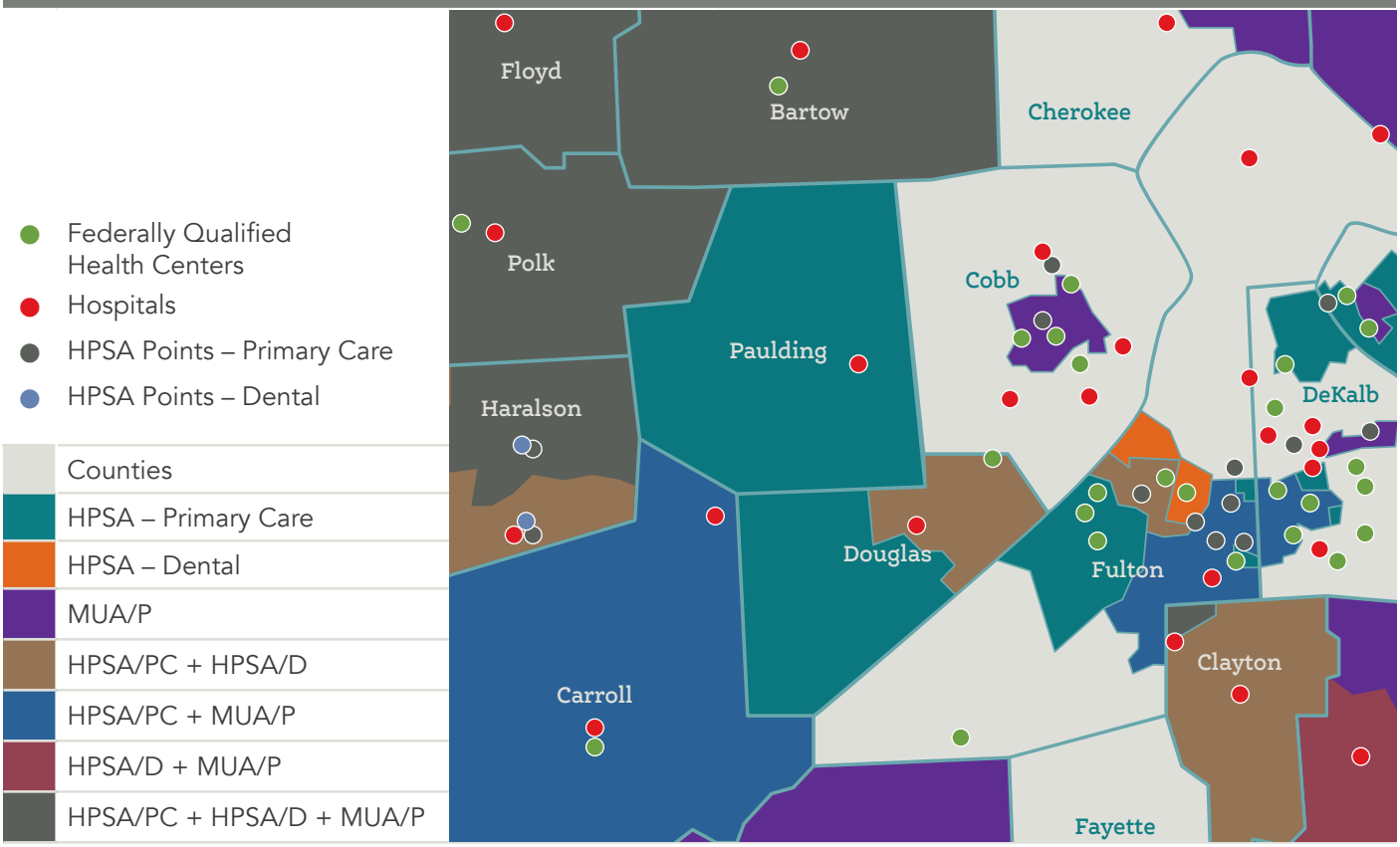
† *Health Resources & Services Administration: Area Health Resource File through County Health Rankings: datawarehouse.hrsa.gov/topics/ahrf.aspx U.S. Census Bureau, 2010 Decennial Census, POS Provider of Services File: www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/index.html*

* *0.00% can result from sample size and margin of error.*

According to the Health Resources and Services Administration (HRSA):

- Health Professional Shortage Areas (HPSAs) exist in all counties in the service area, except Cobb and Cherokee counties.
- Each county, with the exception of Douglas and Paulding, has areas that are designated as geographically Medically Underserved Areas (MUAs).
- Most safety-net providers are located in the downtown area of Atlanta and central Cobb County, leaving few safety-net providers to serve the northern and southern regions of the service area.

Map 3 | Primary Care and Dental HPSAs, Safety-Net Providers and Hospitals†



† *U.S. Department of Health and Human Services, The HRSA Data Warehouse, Primary Dataset: Health Professional Shortage Areas (HPSAs), Secondary Dataset: Medically Underserved Areas/Populations (MUA/P)*

Health Behaviors

To better understand behaviors impacting health, it is important to consider factors influencing the choices residents make that cause them to be either healthy or unhealthy. Often these choices are influenced by access to, awareness of and preference for healthy or unhealthy options.

Food Insecurity

According to the U.S. Department of Agriculture (USDA), food security is access by all people at all times to enough food for an active, healthy life, which is one of several conditions necessary for a population to be healthy and well nourished. In 2016, the USDA found that 14 percent of households in Georgia experience low food security and 5.6 percent experience very low food security.[11]

Community input suggests that residents are not always able to afford healthy food. One resident described the guilt she felt when buying and preparing unhealthy foods for her children, knowing it was not healthy for them. Another resident simply stated:

> "It's cheaper to buy a pack of ramen noodles at 20 cents, than buy an apple for 50 cents."

Table 6 shows that most counties included in this CHNA show signs of food insecurity and low access to grocery stores. Residents in Carroll County have the highest percentage of residents with low food access when compared to the rest of the service area. However, residents of Paulding County have lower access to grocery stores and supermarkets in the service area.

Table 6 | Selected Populations With Low Access to a Supermarket or Large Grocery Store by County (2010-2015)†

	Bartow	Carroll	Cherokee	Cobb	DeKalb	Douglas	Fulton	Paulding
Total Population	102,623	114,898	235,896	739,072	736,066	140,152	1,010,420	152,399
Percent Population Below 100% FPL	14.20%	18.63%	9.44%	10.86%	17.63%	14.21%	16.00%	9.72%
Grocery Stores (2016)*	15.97	23.52	15.86	15.70	21.97	11.33	21.29	8.43
Percent Population with Low Food Access (2015)	29.24%	51.16%	42.66%	40.15%	23.37%	42.60%	30.27%	48.44%

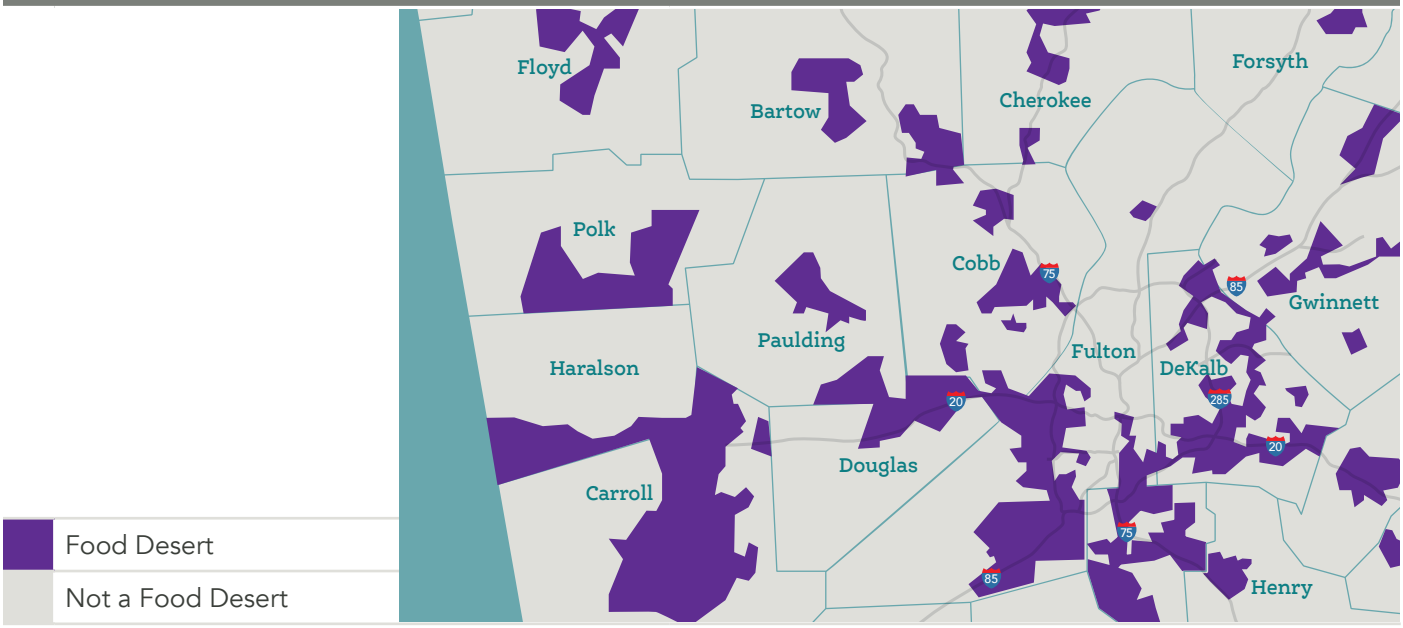
ND: Data was unavailable due to a lack of data reporting or data suppression

† *Low-Income and Low-Supermarket-Access Census Tracts, 2010-2015 (January 2017), Economic Information Bulletin No. (EIB-165) 21 pp*
U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015.
U.S. Census Bureau, American Community Survey. 2013-17.
U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.

* *Per 100,000 population*

11 *USDA Economic Research Service, Household Food Security in the United States in 2016, ERR-237*

Map 4 | Percentage of Low-Income Population With Low Access to a Supermarket or Large Grocery Store†



† *(January 2017), Economic Information Bulletin No. (EIB-165) 21 pp*

All of the primary data sources discussed obesity, healthy nutrition or physical activity as community health needs. Their input suggests that residents do not have time to shop and prepare meals or exercise in a healthy way. Residents discussed lengthy commutes and traffic as the primary reason they did not shop for and prepare healthy meals or exercise in a healthy way.

Long Commute Times

The data in Table 7 shows more people than average for the state of Georgia spend more than one hour commuting in every county, except in Carroll and Fulton counties. One focus group participant said:

> "You have family situations where the parents or the single parent is just too busy and too overwhelmed to also fit into the schedule healthy eating, exercise, family outings because you spend so much time in traffic getting from work to the kids to the grocery store to home."

Table 7 | Selected Healthy Eating, Active Living Indicators†

	Bartow	Carroll	Cherokee	Cobb	DeKalb	Douglas	Fulton	Paulding	Georgia	U.S.
Healthy food stores (low access)	29.20%	51.20%	42.70%	40.20%	23.40%	42.60%	ND	48.40%	30.80%	22.40%
Exercise opportunities (access)	81.50%	62.10%	79.70%	88.80%	96.20%	76.10%	90.00%	75.10%	75.00%	84.30%
Physical inactivity (adults)	25.00%	28.00%	19.70%	18.40%	20.20%	26.10%	18.00%	24.10%	23.10%	21.80%
Driving alone to work, long distances (>60 mins)	42.60%	36.90%	55.80%	51.30%	48.80%	52.60%	37.90%	60.60%	40.00%	34.80%

ND Data were unavailable due to a lack of data reporting or data suppression

† *USDA Food Access Research Atlas (FARA), www.ers.usda.gov/data-products/food-access-research-atlas*
County Health Rankings and Roadmaps: countyhealthrankings.org
NCCDPHP National Center for Chronic Disease Prevention and Health Promotion: www.cdc.gov/nccdphp/dnpao/index.html
U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: www.census.gov/acs/www/

There are existing resources throughout the service area that address healthy behaviors, parent education and family support.[12] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the barriers to healthy behaviors, parent education and family support noted in this assessment.

12 See the Community Facilities, Assets and Resources section of the Appendix for a list of resources.

Health Outcomes

Most of the top five causes of death in the service area are related to chronic conditions, lifestyle, behaviors (i.e., heart disease, COPD, lung cancer and stroke) or behavioral health and substance abuse issues. Across the service area, residents of Bartow and Carroll counties have a higher disease burden and death rate. Black and Multiracial residents have the poorest health outcomes (often higher than state rates) when compared to any other racial or ethnic cohort in the service area.

Health Summit attendees discussed health disparities in the region. They noted the importance of finding a way to address health disparities to improve health outcomes. Discussions centered on providing services that are culturally and linguistically relevant to residents and the need to address disparities in social determinants of health (education, poverty, etc.) along with health outcomes. The following causes depict geographic and racial disparities that exist in the service area.

Top Causes of Premature Death

The top five causes of premature death are derived from the Years of Potential Life Lost 75 (YPLL 75) and represent the number of years of potential life lost due to death before age 75 as a measure of premature death. In the service area, premature death seems to be caused by heart disease, poisoning, perinatal conditions, suicide and assault/homicide. The rate of premature death due to poisoning is particularly high across the CHNA region served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. There are notable inequities when premature death is considered by race, with Black residents showing much higher rates when compared to all other races (when data are available).

Table 8 | Years of Potential Life Lost Rates (Premature Death) (2017)*†

By Region	Ischemic Heart and Vascular Disease	Accidental Poisoning and Exposure to Noxious Substances	Certain Conditions Originating in the Perinatal Period	Intentional Self-Harm (Suicide)	Assault (Homicide)
Bartow	809.70	801.70	ND	409.90	ND
Carroll	791.10	673.90	ND	652.40	253.60
Cherokee	431.70	620.20	220.70	442.00	99.50
Cobb	330.70	603.50	380.70	421.80	176.50
DeKalb	307.40	356.70	558.70	328.80	583.50
Douglas	653.50	532.40	ND	296.60	210.90
Fulton	321.30	477.40	291.70	384.90	490.80
Paulding	509.70	589.40	ND	471.30	262.80
Georgia	524.80	477.90	360.00	429.80	338.60
By Race**					
White	458.50	834.90	112.00	541.70	67.50
Black	419.60	291.50	615.70	303.90	835.80
Hispanic‡	127.80	171.30	344.00	245.90	225.60
Asian	89.90	ND	350.00	127.10	129.80
American Indian	ND	ND	0.00	0.00	0.00
Pacific Islander	0.00	0.00	0.00	0.00	0.00
Multiracial‡	ND	ND	711.60	ND	0.00

ND for rates: Rates based on 1-4 events are not shown

0.00 can result from sample size and margin of error

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Top Causes of Death

Reported causes of death are based on the underlying cause of death. The underlying cause of death is defined by the World Health Organization as the disease or injury that initiated the sequence of events leading directly to death or as the circumstances of the accident or violence that produced the fatal injury. All of the top five causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, COPD, lung cancer and stroke). It is important to note that the top cause of death is cardiovascular in nature. Georgia is well known to have poor outcomes related to cardiovascular disease, and Bartow, Carroll, Douglas and Paulding counties all show higher rates of mortality than the state in coronary heart disease. Black residents show higher rates of death compared to their racial counterparts (when data are available).

Table 9 | Age-Adjusted Death Rates (2017)*†

By Region	Ischemic Heart and Vascular Disease	All COPD Except Asthma	Malignant Neoplasms of the Trachea, Bronchus and Lung	Cerebrovascular Disease	All Other Mental and Behavioral Disorders
Bartow	94.50	89.80	40.20	39.50	34.80
Carroll	85.40	114.20	52.40	40.30	16.30
Cherokee	58.00	74.50	35.30	49.80	21.70
Cobb	53.90	56.40	29.40	53.70	17.90
DeKalb	48.40	53.20	26.90	35.90	22.80
Douglas	83.80	70.60	36.30	45.40	31.80
Fulton	50.00	53.50	28.40	40.90	24.90
Paulding	80.70	109.30	43.70	49.10	23.20
Georgia	73.10	81.70	38.90	43.40	30.80
By Race**					
White	57.90	70.20	32.40	40.20	20.60
Black	61.00	53.50	33.50	53.00	32.00
Hispanic‡	29.10	18.40	8.30	19.70	6.00
Asian	21.30	27.40	14.60	21.90	7.20
American Indian	ND	0.00	0.00	0.00	0.00
Pacific Islander	0.00	0.00	0.00	0.00	0.00
Multiracial‡	ND	ND	0.00	26.50	ND

ND for rates: Rates based on 1-4 events are not shown

0.00 can result from sample size and margin of error

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Top Causes for Emergency Department Visits

There is anecdotal evidence that residents are seeking care in the ED for a variety of reasons such as lack of insurance, limited availability of after-hours care or acute symptoms. Three of the top causes of ED visits in the service area are all related to accidents. Overall, Bartow, Carroll, Douglas and Paulding counties showed rates higher than the state average for each cause of ED visits. Multiracial residents have significantly higher rates than other races and the state for each cause of ED visits in the service area.

Table 10 | Age-Adjusted Emergency Room Visit Rates (2017)*†

By Region	All Other Unintentional Injury	Diseases of the Musculoskeletal System and Connective Tissue	All Other Diseases of the Genitourinary System	Falls	Motor Vehicle Crashes
Bartow	5,083.20	4,989.10	3,654.40	2,940.20	1,301.00
Carroll	3,939.70	5,357.80	3,899.90	3,064.10	1,582.60
Cherokee	2,467.30	1,706.10	1,858.90	1,918.10	869.00
Cobb	1,919.50	2,002.10	1,630.40	1,455.40	1,020.80
DeKalb	1,552.80	3,272.30	1,964.50	1,054.30	1,035.70
Douglas	3,807.80	4,034.40	3,052.90	2,333.00	1,796.10
Fulton	1,906.80	3,261.30	2,027.80	1,272.20	991.10
Paulding	3,745.60	3,302.70	2,560.30	2,489.50	1,486.50
Georgia	3,030.00	3,276.90	2,394.20	1,918.40	1,168.80
By Race**					
White	1,912.60	1,682.90	1,473.10	1,574.30	609.30
Black	2,567.70	5,198.10	2,961.10	1,342.90	1,722.10
Hispanic‡	ND	ND	ND	ND	ND
Asian	494.70	464.00	377.40	433.80	255.60
Native American	2,894.30	2,064.90	2,113.80	1,818.40	1,177.20
Pacific Islander	1,463.80	1,349.60	1,112.50	1,693.30	478.30
Multiracial‡	7,535.20	8,122.20	7,013.40	5,522.30	4,546.10

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Top Causes for Hospital Discharges

The number of inpatients discharged from non-federal acute-care inpatient facilities that are residents of Georgia and seen in a Georgia facility is considered in the following table. Uninsured residents are not always admitted to the hospital without some form of payment and may not be represented heavily in this measure. Hospital discharge rates are highest for childbirth and mental and behavioral disorders. Overall, residents of Bartow and Paulding counties have higher hospital discharge rates when compared to the service area and state. Multiracial residents have significantly higher rates than other races and the state for each cause of hospital discharge in the service area.

Table 11 | Age-Adjusted Hospital Discharge Rates (2017)*†

By Region	Pregnancy, Childbirth and the Puerperium	Diseases of the Musculoskeletal System and Connective Tissue	Ischemic Heart and Vascular Disease	Septicemia	All Other Mental and Behavioral Disorders
Bartow	1,367.40	596.10	432.70	938.90	1,027.30
Carroll	1,241.30	536.30	418.10	733.40	949.60
Cherokee	1,297.00	522.00	209.80	292.30	433.10
Cobb	1,286.30	456.60	170.70	353.70	461.00
DeKalb	1,499.90	409.90	188.80	413.20	553.60
Douglas	1,338.50	466.80	256.20	700.80	605.40
Fulton	1,160.70	429.80	190.60	500.10	553.30
Paulding	1,299.30	518.60	285.10	546.50	599.00
Georgia	1,289.50	489.30	531.50	514.50	255.30
By Race**					
White	1,006.80	477.80	199.90	405.20	477.10
Black	1,366.10	414.50	223.90	570.80	692.10
Hispanic‡	ND	ND	ND	ND	ND
Asian	1,116.50	143.10	81.60	159.80	44.80
Native American	2,578.30	603.20	201.90	338.00	136.70
Pacific Islander	1,222.00	493.50	1,409.20	550.20	ND
Multiracial‡	6,774.00	1,197.60	985.20	1,755.90	1,774.90

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Obesity

At the time of this CHNA, high body mass index (BMI) is a health issue throughout the country, with this community being no exception. Nearly one in three adults are obese. Community leaders and residents noted that people do not always have access to physical activity. Parents do not always feel it is safe to send children outside to play. One resident explained why her children do not go to the park:

> "My children are of an age where you would think they could go to the park by themselves, but because of everything that's going on crime wise, kidnapping, assaulting and shooting, all kind of stuff going on, a lot of innocent people getting hurt, it's a fear of that."

Residents of Bartow, Carroll, Douglas and Paulding counties have diabetes diagnoses that are higher than the state average. Carroll and Douglas counties also show higher rates of diabetes mortality. Black residents show higher rates of hospital discharge and death than any other race.

Table 12 | Selected Adult BMI and Diabetes Indicators by County and Race†

By Region	Adult Obesity (2014)	Diagnosed Diabetes (2013)	Diabetes discharge rate* (2013-17)	Diabetes mortality* (2013-17)
Bartow	34.20%	12.10%	229.40	13.80
Carroll	32.90%	11.30%	153.80	28.40
Cherokee	25.10%	8.50%	103.10	13.00
Cobb	27.50%	8.70%	147.10	14.20
DeKalb	27.20%	10.00%	219.70	21.00
Douglas	32.00%	12.00%	214.40	23.30
Fulton	25.80%	8.70%	186.60	17.50
Paulding	29.00%	11.00%	163.10	13.30
Georgia	30.00%	10.60%	188.10	21.70
By Race**				
White	ND	ND	105.30	12.00
Black	ND	ND	310.70	31.90
Hispanic‡	ND	ND	229.40	13.80
Asian	ND	ND	32.70	10.40

ND Data: Unavailable due to a lack of data reporting or data suppression

† *County Health Rankings and Roadmaps: countyhealthrankings.org*
Centers of Disease Control and Prevention, Diagnosed Diabetes Prevalence: www.cdc.gov/diabetes/data/countydata/countydataindicators.html
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Age adjusted, per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Heart Disease

The southeast region of the United States has higher morbidity and mortality rates related to cardiovascular conditions (i.e., cerebrovascular obstructive and hypertensive heart disease). As a result, some counties reflect elevated cardiovascular disease when compared to the state average. In particular, Bartow, Carroll and Paulding counties show higher rates of morbidity related to obstructive heart disease, while Bartow and Carroll counties also show higher rates of mortality. All counties in the service area except Cherokee and Cobb counties have higher rates of morbidity from hypertensive heart disease. When compared to the state, Black residents show higher rates of heart disease morbidity and mortality, while Asian residents show higher rates of stroke mortality.

Table 13 | Selected Cardiovascular Condition Indicators by County and Race (2013-2017)*†

By Region	Obstructive heart disease/ heart attack discharge rate*	Obstructive heart disease mortality*	Hypertensive heart disease discharge rate*	Hypertensive heart disease mortality*	Stroke mortality*	Stroke Prevalence (2015)
Bartow	442.50	88.60	77.70	26.00	47.30	4.60%
Carroll	401.30	87.20	54.10	20.60	48.90	4.20%
Cherokee	224.20	56.50	27.90	15.30	39.80	4.30%
Cobb	180.00	51.40	28.40	7.60	44.00	4.50%
DeKalb	205.70	53.20	47.20	14.90	40.50	4.60%
Douglas	255.70	57.20	43.80	5.90	44.20	4.50%
Fulton	195.30	56.30	47.80	24.40	39.20	4.00%
Paulding	303.60	63.50	45.40	21.90	42.20	4.40%
Georgia	265.00	76.40	39.00	16.30	43.00	4.20%
By Race**						
White	208.60	57.20	27.80	12.60	37.00	ND
Black	235.30	62.70	70.10	28.10	51.70	ND
Hispanic‡	ND	22.10	ND	4.10	ND	ND
Asian	86.20	31.20	10.30	7.20	30.00	ND

ND Data: Unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse: www.cms.gov/

* *Age adjusted, per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Cancer

Cancer rates are also elevated in Georgia when compared to the national average. There are higher morbidity rates for breast, colon, lung and prostate cancers across the service area. Bartow, Carroll, Douglas and Paulding counties have cancer mortality rates higher than the state average.

Table 14 | Selected Cancer Indicators by County and Race (2011-2017)†

By Region	Breast cancer incidence (2011-15)*	Cervical cancer incidence (2011-15)*	Colon and rectum cancer incidence (2011-15)*	Prostate cancer incidence (2011-15)*	Lung cancer incidence (2011-15)*	Cancer mortality (2013-17)*
Bartow	118.70	11.80	49.60	97.30	80.50	170.30
Carroll	120.00	7.40	48.70	107.30	82.50	189.60
Cherokee	123.20	6.40	37.00	114.90	66.00	148.00
Cobb	135.20	6.00	40.20	131.70	57.10	143.50
DeKalb	136.00	6.70	40.60	143.90	51.20	150.10
Douglas	130.80	8.60	42.30	129.90	68.30	172.40
Fulton	132.10	6.90	38.10	143.80	51.20	144.60
Paulding	122.00	8.00	44.20	113.60	75.60	169.60
Georgia	125.20	7.80	41.80	123.30	64.90	160.70
U.S.	124.70	7.50	39.20	109.00	60.20	148.00
By Race**						
White	ND	ND	38.20	112.20	60.10	144.30
Black	ND	ND	45.90	192.00	55.90	173.20
Hispanic‡	ND	ND	29.60	93.00	37.10	ND
Asian	ND	ND	29.10	45.40	23.60	77.60

ND Data: Unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

† *CARES Engagement Network: National Cancer Institute and Center for Disease Control and Prevention, State Cancer Profiles: statecancerprofiles.cancer.gov*

Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Age adjusted, per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Asthma

Asthma is common in densely populated urban areas for a variety of reasons. Residents living in Bartow, DeKalb, Douglas and Fulton counties also suffer from higher morbidity rates for asthma. Specifically, residents from DeKalb, Douglas and Fulton counties show higher hospitalization and ED visits for asthma.

Table 15 | Selected Respiratory Indicators by County and Race (2013-2017)†

By Region	Asthma discharge rate*	Asthma ED visit rate*
Bartow	91.90	495.90
Carroll	34.80	543.20
Cherokee	57.70	267.10
Cobb	77.30	499.90
DeKalb	123.10	738.60
Douglas	99.70	831.60
Fulton	103.60	651.90
Paulding	82.90	549.40
Georgia	87.5	551.6
By Race**		
White	58.10	255.40
Black	155.20	1,140.90
Hispanic‡	ND	ND
Asian	19.20	98.80

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

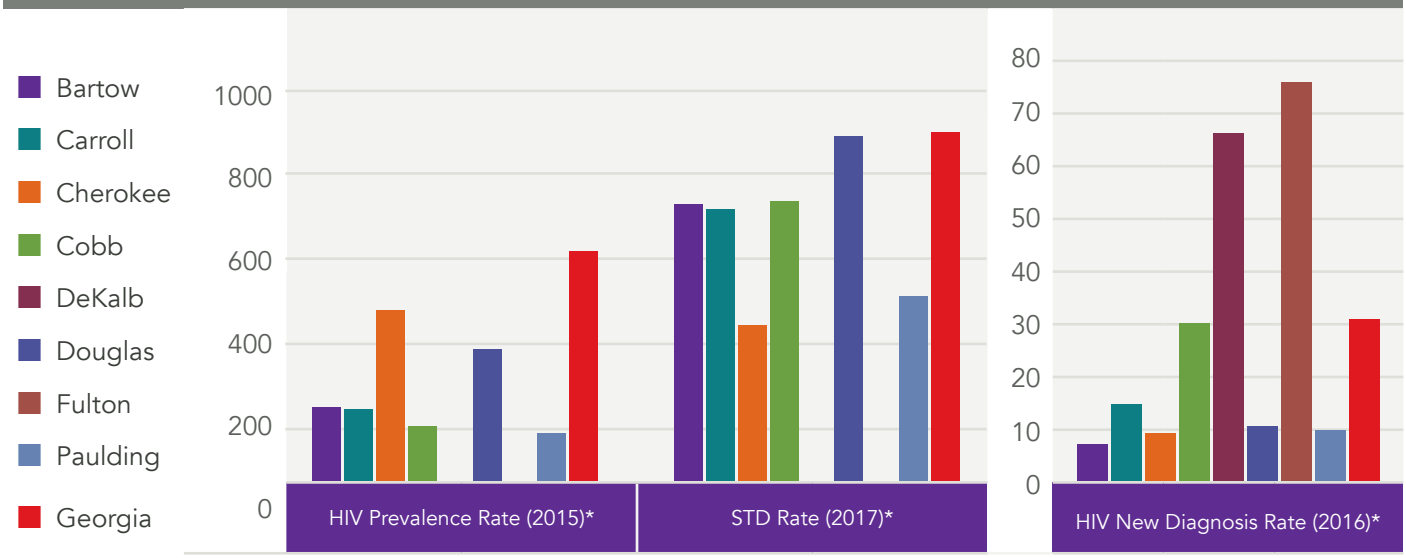
Sexually Transmitted Infections (STIs)

The Atlanta metropolitan area has some of the highest morbidity rates for human immunodeficiency virus (HIV) and AIDS in the nation. DeKalb and Fulton counties shows higher rates of HIV prevalence and new HIV diagnoses when compared to the state. A closer look at zip-code-level data shows a more complex picture of HIV in this region.[13,14]

While HIV screening rates are high in the service area, annual diagnostic rates remain high among certain populations, according to a database called AIDSVu, managed by the Rollins School of Public Health at Emory University. Specifically, in the service area:

- The highest rates of prevalence and new cases are among Fulton County residents.
- Black men are being diagnosed with HIV at a much higher rate than any other racial or ethnic group.[15]

Figure 6 | Prevalence and Diagnoses Rates for HIV and All Other STIs†



Rates based on 1-4 events are not shown

† *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Age adjusted, per 100,000 population*

13 HIV data are not available at the zip code level for 30114 and 30028.

14 See the Secondary Data section of the appendix for zip code-level data on HIV prevalence and new cases. 16 30350, 30093, 30092, 30328 and 30096

15 AIDSVu. Emory University, Rollins School of Public Health. Atlanta, GA (www.aidsvu.org)

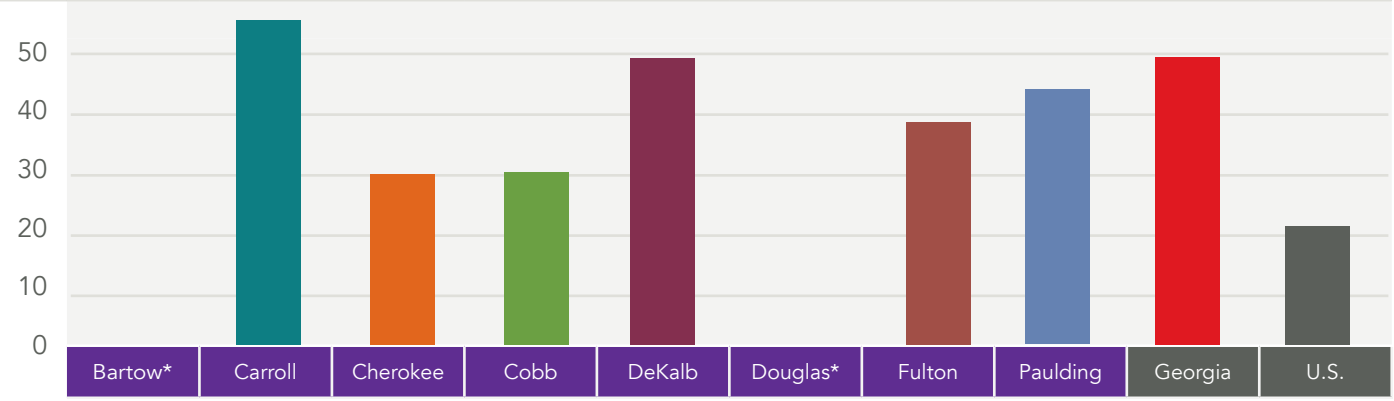
Birth Outcomes

Most birth outcomes in Georgia need improvement when compared to national averages. One of the greatest challenges the state faces in addressing infant outcomes is consistent collection, tabulation and presentation of complete data related to childbirth across the state. According to the 2016 State of the State Report, Georgia continues to face challenges related to the prevalence of low-birthweight infants and infant mortality, among other issues.[16]

Georgia has the highest maternal mortality in the nation. All counties, for which there are data available, show much higher rates of maternal mortality when compared to the U.S. Carroll County shows the highest maternal mortality rate when compared to the state and all other counties in the service area.

Figures 7 and 8 show that the general population in DeKalb and Fulton counties have rates of low-birthweight births higher than the state average. DeKalb County also has a higher infant mortality rate than the state. Black residents in all counties are nearly twice as likely to experience infant mortality as any other race (when data are available).

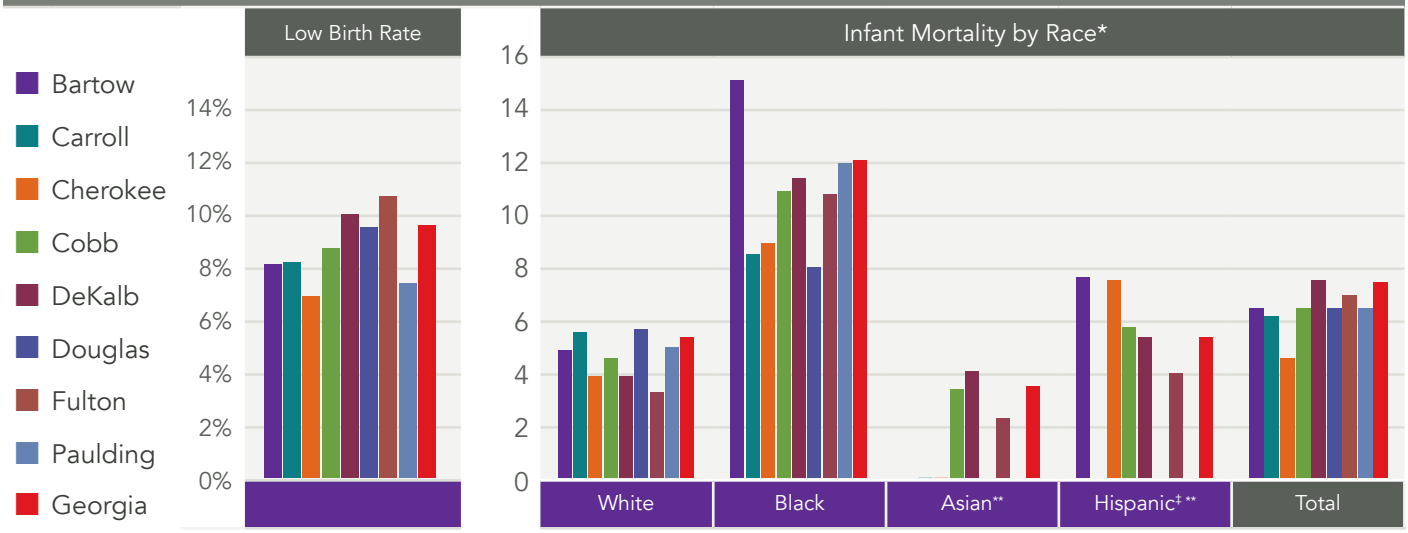
Figure 7 | Maternal Mortality Ratio†



† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *0.00% can result from sample size and margin of error*

Figure 8 | Infant Mortality and Low Birth Weight by County†



† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Number of infant deaths per 1,000 live births* ** *Rates based on 1-4 events are not shown*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

16 *Healthy Mothers, Healthy Babies Coalition of Georgia, 2016 State of the State of Maternal and Infant Health in Georgia https://drive.google.com/file/d/0BxndQpkPFFfySm5aNmdkYXZYQm8/view*

Injury and Assault

Table 16 shows that assault rates are particularly high in DeKalb and Fulton counties. Also, residents of Bartow, Carroll, Douglas and Paulding counties have higher rates of ED visits due to motor vehicle crashes.

Table 16 | Selected Injury Indicators (2013-2017)†

	Bartow	Carroll	Cherokee	Cobb	DeKalb	Douglas	Fulton	Paulding	Georgia
Assault discharge rate (2013-17)*	10.00	11.80	10.00	5.30	36.40	9.80	42.60	6.50	18.60
Motor vehicle crash ED visit rate (2013-17)*	1,170.5	1,548.0	972.7	830.7	1,008.8	1,581.2	898.0	1,388.6	1,099.9
Impaired Driving Deaths (2011-15)	17.70%	25.30%	24.80%	18.80%	22.40%	29.20%	22.80%	10.90%	23.40%

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
Health Resources & Services Administration: Area Health Resource File through County Health Rankings: datawarehouse.hrsa.gov/topics/ahrf.aspx

* *Age adjusted, per 100,000 population*

Behavioral Health

The need for behavioral health resources, particularly for under- and uninsured patients, is a challenge across the state of Georgia. Health Summit participants prioritized behavioral health as one of the most pressing issues in the community that, if addressed, could influence the health of residents. According to the Georgia Hospital Association, about 50,000 people across the state were admitted to Georgia's hospitals for mental health issues in 2016.[17]

According to community input, behavioral health issues impact all demographics. Focus group residents and Health Summit participants indicated that there is a shortage of providers, particularly for uninsured behavioral health, treatment for co-occurrence of behavioral health and substance abuse and adolescent treatment. Residents and community leaders noted that suicide rates are high in the area and there are few cultural and linguistically sensitive treatment options available.

This area has shown a slight need for behavioral health providers, with an estimated 19,278 residents living in areas with professional shortages. Meanwhile, mental and behavioral disorders are one of the top five causes of death in the service area and intentional self-harm (suicide) is one of the top five causes of premature death. Hospital and community leaders discussed the resistance of residents to seek behavioral healthcare when it is needed for themselves or their children due to limited awareness about signs and symptoms, as well as fear of stigma. One resident noted:

> "And people make mental health such a taboo, I don't know why, but it's really needed."

17 *Overwhelmed In The ER: Georgia's Mental Health Crisis (Feb. 28, 2018), Elly Yu, https://www.wabe.org/overwhelmed-er-georgias-mental-health-crisis/*

Table 17 shows low mental health provider rates in Bartow, Carroll, Cobb, Douglas and Paulding counties when compared to the rest of the service area. It is important to note there is no measure of the rate of behavioral health providers that offer care to uninsured patients. Input from community residents related to behavioral health also suggested that residents might resist seeking care due to lack of insurance, unaffordable cost of care and providers being located too far from home. Table 17 also shows a much higher rate of ED use in Bartow, Carroll, Fulton and Paulding counties when compared to all other counties in the service area and the state. This may point to barriers to accessing treatment in more appropriate settings.

Table 17 | Selected Behavioral Health Characteristics by County†

	Bartow	Carroll	Cherokee	Cobb	DeKalb	Douglas	Fulton	Paulding	Georgia
Mental health providers (2016)*	97.3	88.2	130.6	79.7	247.0	68.2	191.2	30.9	115.0
Poor mental health days (2015)**	3.7	4.0	3.4	3.5	3.7	3.7	3.6	3.5	3.8
Mental health ED rate (2017)*	1,502.1	1,353.0	965.1	864.4	1,015.7	1,314.3	1,502.4	1,194.1	1,094.6
Mental and behavioral disorder mortality (2013-17)*	34.8	30.1	29.5	31.4	34.3	34.0	33.3	19.0	37.4
Self-harm age-adjusted discharge rate (2013 -17)*	54.3	36.8	30.4	27.5	28.2	28.1	25.4	37.5	32.7
Age-adjusted suicide mortality (2013-17)*	17.5	16.9	11.5	14.4	7.9	10.7	10.4	13.6	12.7

† *County Health Rankings and Roadmaps: countyhealthrankings.org*
Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System through County Health Rankings: www.cdc.gov/brfss/
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Per 100,000 population*

** *Age-adjusted average number of self-reported mentally unhealthy days per month among adults.*

Substance Abuse

Substance abuse has become an increasing concern in many parts of the United States in the last decade, specifically related to opioid abuse and overdose. Every primary data source discussed substance use, particularly opioid abuse and overdoses, as a community health priority, including the WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals' Health Boards and community leaders attending the Health Summit. One resident described the risk to children this way:

> "People used drugs freely on the corner and kids had to really stay under your wing because if you didn't, they'd end up drug addicts."

Another resident explained some of the challenges residents face when trying to rehabilitate from addiction:

> "You have private places like residential rehab that are expensive. Stuff that may actually be beneficial and effective are probably expensive; or you've got to schedule time to be away from your home or your job or whatever to be going to this thing [rehabilitation] for a period of time in order to benefit from a treatment facility. Typically, I believe that most people or the average person's introduction to a treatment facility is through court after a judge has to send them there."

Death due to accidental poisoning and exposure to noxious substances, which includes drug overdoses, is one of the top five causes of premature death in the service area. Table 18 shows that the mortality rate due to drug overdose has increased across the service area.

Table 18 | Rate of Drug Overdose by County (2007-2017)†

	Bartow	Carroll	Cherokee	Cobb	DeKalb	Douglas	Fulton	Paulding	Georgia
Drug overdoses (2007)*	7.80	21.50	11.20	6.20	6.00	7.30	10.90	14.50	8.60
Drug overdoses (2017)*	25.80	27.50	16.70	18.10	10.20	16.00	14.50	15.50	14.60

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

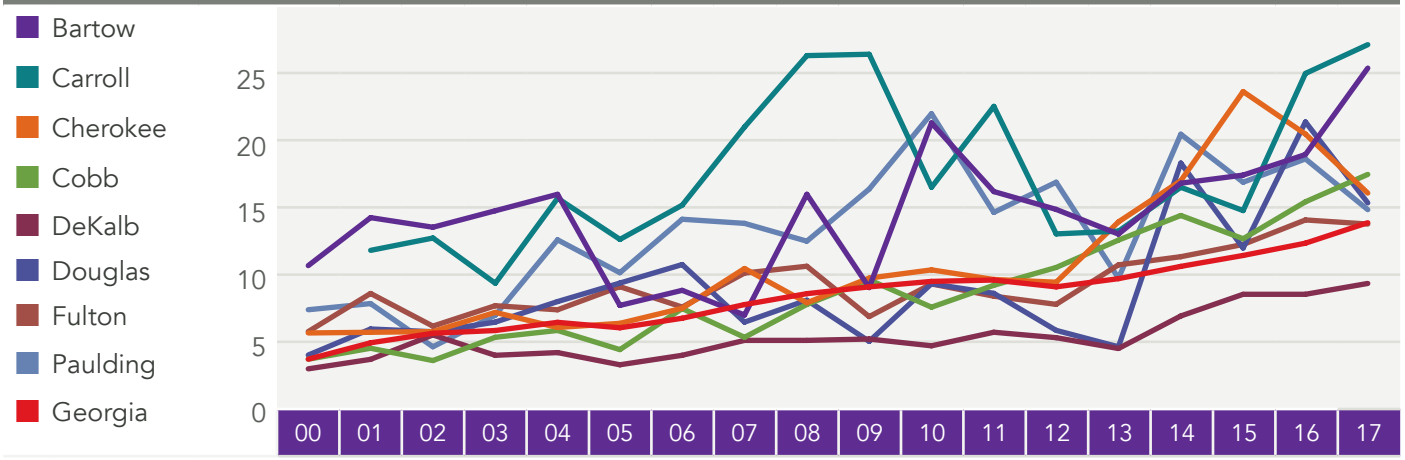
* *Per 100,000 population*

According to a white paper written and presented to the State Senate by the Georgia Prevention Project's Substance Abuse Research Alliance:

- 68 percent of the 1,307 drug overdose deaths in 2015 in Georgia were due to opioid overdoses, including heroin.
- A statistically significant increase in the drug overdose death rate occurred from 2013 to 2014.
- Overdose deaths tripled between 1999 and 2013 in Georgia.[18]

Figure 9 shows the increase of substance abuse overdoses across the service area since 1999. Carroll County shows the highest rate when compared to the rest of the counties in the service area and state.

Figure 9 | Age-Adjusted Death Rate by Drug Overdoses Per 100,000 Population (1999-2016)†



† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

There are existing resources throughout the service area that address the common health outcomes noted in this section.[19] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the health issues.

18 *Georgia Prevention Project: Substance Abuse Research Alliance, Prescription Opioids and Heroin Epidemic in Georgia (2017), www.senate.ga.gov/sro/Documents/StudyCommRpts/OpioidsAppendix.pdf*

19 *See the Community Facilities, Assets, and Resources section of the Appendix for a list of resources.*

Community Is **Compassion**

RALLYING PEOPLE AND RESOURCES

Community Input

This assessment engaged residents and leaders from the community who provide services in the community served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. An in-depth description of the participants, methods used and collection period for each qualitative process is located in the Primary Data and Community Input section of the Appendix.

Listening Session

A listening session was conducted with each hospital's Regional Health Board and key informant interviews were conducted with 15 community leaders. Hospital and community leaders encompassed a wide variety of professional backgrounds, including (1) public health expertise, (2) professionals with access to community health-related data and (3) representatives of under-resourced populations. The listening session and interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to the CHNA.

Focus Groups

Two focus groups were conducted to gather input from more than 20 residents living and working in the community served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. Focus group participants were asked to discuss their opinions related to the health status and outcomes; context, facilitating and blocking factors of health; and what is needed to be healthier in their community. The following pages are a summary of the community input gathered during the CHNA process.

Summary of CHNA Community Input

WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill Hospitals

Commonly Discussed Health Issues

- Common health issues:
  - Obesity (adult and childhood)
  - Cardiovascular disease (hypertension, high cholesterol)
  - Diabetes (Type I and II)
  - Stroke
  - Kidney disease
  - Cancer (lung, colon, gastric, breast)
  - Infectious disease (HIV, syphilis, gonorrhea, chlamydia, Hepatitis C)
  - Respiratory issues among homeless populations (COPD and asthma)
  - Infant mortality
- Mental health (depression, anxiety, stress):
  - High prevalence of untreated/undiagnosed mental issues
  - Self-harm/suicide
- Substance abuse (marijuana, crack/cocaine, opioid/heroin, alcohol, methamphetamines)
- Poor dental health among uninsured
- Disparities among people of color
- Poor eye sight and attention span (related to screen time)

Commonly Discussed Causes

- Transportation
  - Limited access to public transportation, including in Douglas and Paulding counties
  - Geographic location of health services coupled with limited transportation options that are fragmented and unreliable
  - Many under-resourced residents do not have access to private transportation
- Low health literacy/awareness of:
  - Available services
  - Healthy practices
  - Prevention
- Limited services available for:
  - Underinsured and uninsured (treatment for cancer and kidney disease, specialty care, inpatient, outpatient, psychiatry, behavioral health, dental, prenatal care)
  - Specialty care (neurologists and OB/Gyn)
  - Behavioral health (therapy, medication, inpatient treatment for co-occurrence with substance abuse)
  - Residents covered by Medicaid or Marketplace insurance
  - The health services that are available in under-resourced communities can be perceived as sparse and low quality
  - Providers are not taking the time to build trust with patients
- Substance abuse:
  - Opioid use is increasing, causing higher overdose rates
  - High rates of abuse and addiction (methamphetamines and alcohol) among homeless and previously incarcerated residents
  - Smoking/vaping among youth
  - Recruiting physicians to rural areas is challenging
- Unaffordable cost:
  - Prescriptions
  - Preventive care
  - Insurance (policies, co-pays, deductibles)
  - Healthy food options
  - Uninsured care (primary, preventive, behavioral health care)
- Poor socioeconomic status associated with:
  - Economic insecurity
  - Poor employment options (low wage) and employment skills
  - Poor educational attainment
- Commute times leave little time for grocery shopping, cooking, physical activity
- Prevalence of fast food
- Limited culturally and linguistically relevant health services — Black and Latino
- Homelessness

	Geographic Areas of Interest	Vulnerable Populations
There is limited investment in healthy infrastructure (sidewalks, parks, street lighting, etc.)	South West Cobb	People of color – African-Americans and Hispanics
Air quality is poor, which influences respiratory disease.	Mableton	Rural areas
Unhealthy cultural preferences, norms and traditions	Austell	Uninsured and underinsured
There is a stigma associated with mental health diagnosis and treatment among Black residents	City of Austell	Previously incarcerated
Racial and ethnic disparities:	Powder Springs	Immigrants (Hispanic and African)
Undocumented residents do not have access to insurance	Smyrna (pockets)	Homeless
Barriers related to language and low literacy levels make effective communication difficult	Marietta Square	People diagnosed with behavioral health challenges or chronic disease
	North Douglas County	Low socioeconomic status (poverty and education)
	Downtown Douglasville	Seniors
	Lithia Springs	
	South Gwinnett County	
	Transient tent cities	

Common Recommendations

Begin to identify and refer patients with needs related to social determinants of health.	Offer transportation to and from medical services weekly or monthly, specifically in under-resourced communities.	Address health needs in policy, systems and environments where they occur.
Advocate for Medicaid expansion and more medical schools to train professionals.	Increase information that is available about the need for healthy physical activity and the resources that are available in local communities.	Divert people from the penal system when they have behavioral health issues.
Provide behavioral health crisis beds, detoxification services, counseling services and psychiatric care to under-resourced residents, including in Cobb County.	Increase education and training of providers related to cultural, racial and ethnic sensitivity. Talk with community leaders and representatives of various populations to better understand what the barriers and issues are for communities in seeking and securing effective treatment options.	Interface more regularly with public health departments.
Increase incentives to work in mental health field.	Work directly with non-health-related organizations and churches to offer up-to-date information and referral directories.	Increase the electronic resources available in communities.
Implement national best practices to address local health needs.	Offer comprehensive adolescent health education in schools.	Focus on addressing the root causes of these health issues.
Increase culturally and linguistically relevant outreach and education about the need to secure a medical home, manage chronic disease, secure preventive care, the value of treatment, prescription assistance programs, etc.	Increase early prevention and intervention methods (e.g., screenings and referral, education, etc.).	Promote physical activity and movement in recreation centers and other locations in the community during winter months.
Support local farmers' markets to offer fresh produce in communities where it is not readily available. Ensure that diabetics have access to nutritious and healthy options.	Look for public-private partnership opportunities to address needs.	Expand the Mental Health First Aid Program into Cobb County, including churches.
		Offer incentives to seek preventive care (e.g., reduction in insurance premiums and monetary rewards).
		Employers could offer healthy options at work (e.g., gym facilities, healthy meals and snacks).

Community Is **Collaboration**

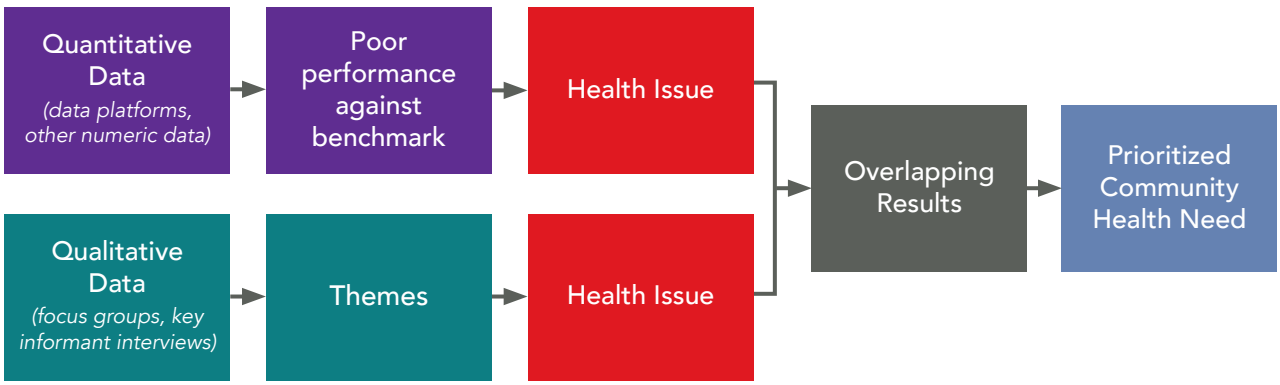
STRONGER TOGETHER

Community Health Priorities

WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals engaged 25 community and hospital leaders to help establish the community priorities for the community served during a Health Summit held December 6, 2018, at the WellStar Development Center. Stakeholders represented organizations serving residents in the primary service areas of WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. An in-depth summary of the results, along with a description of the participants, methods used and collection period, is located in the Primary Data and Community Input section of the Appendix.

GHPC presented to community leaders findings from the CHNA generated from analysis of secondary data, key informant interviews, focus groups and listening sessions (see Figure 10).

Figure 10 | Process Used to Identify the Most Pressing Health Needs



The most pressing health needs presented during the Health Summit included:

- Uninsured
- Poverty
- Educational attainment
- Provider rates
- Hospital utilization rates
- HIV and STI
- Cardiovascular disease
- Maternal and child health outcomes
- Cancer
- Obesity/BMI
- Diabetes
- Healthy eating, active living indicators
- Behavioral health
- Substance use

Community leaders were then asked to discuss the health needs of the community they serve and encouraged to add any needs that may have been absent from the data presented. Grouped by self-selected tables, participants were asked to identify the top five health needs that they believed, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the health of the community, especially the most vulnerable populations. Needs that were identified by individual groups were consolidated into mutually exclusive health priorities and voted upon to surface the community health priorities, listed in the order they were prioritized. Health Summit attendees also identified racial and ethnic disparities as cross-cutting theme and an influencer of each community health priority. As a result, this assessment reports racial and ethnic data where they are available, which will inform strategy development.

1 Access to appropriate care

Health Summit attendees discussed the limited access that residents have to appropriate care when and where they need it. As the top priority in the service area, attendees discussed the need for transportation, preventive care, insurance coverage options and providers (primary, dental, behavioral healthcare and specialty providers, including diagnostic labs and chronic disease management).

2 Chronic disease

Health Summit attendees discussed the need to address chronic diseases in the community. Concerns among summit attendees included the need for healthy food options, physical activity opportunities, awareness and educational opportunities related to healthy nutrition and physical activity for residents. Summit attendees also felt that obesity, heart disease and diabetes rates are high.

3 Behavioral health

Health Summit attendees prioritized behavioral health as one of the most pressing issues in their communities. Attendees noted that addressing behavioral health in their communities will require collaboration among organizations. Their concerns included: stigma, limited providers (inpatient, outpatient, co-occurrence, etc.), a lack of culturally and linguistically sensitive treatment options and limited resources for uninsured residents.

4 Substance abuse

Health Summit attendees prioritized substance abuse as one of the most pressing issues in their communities. Attendees noted that addressing substance abuse needs in their communities will improve health outcomes. Their concerns included: the availability of life-saving prescriptions like Naloxone, limited providers (detoxification, co-occurrence, etc.) and the balance between effective pain management and availability of addictive pain prescriptions in medical care settings.

5 Maternal and child health

Health Summit discussions addressed the importance of maternal and child health in the community served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. Attendees discussed the prevalence of maternal mortality, infant mortality, disparities among people of color and lack of prenatal care for undocumented and uninsured women.

Community **Impact**

BUILDING AND ALIGNING FOR HEALTH EQUITY

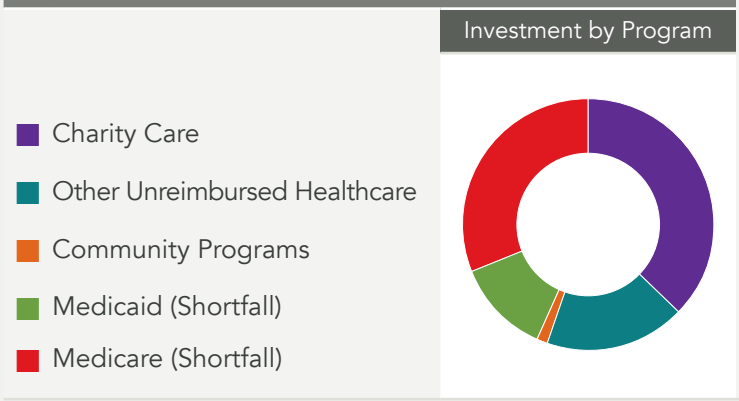
Community Benefit Through the Years

At WellStar, the Community Benefit strategy has moved beyond IRS requirements – from compliance to strategic alignment – which allows the system to improve community health and demonstrate return on investment for Community Benefit activities. Maintaining efforts beyond the three-year Community Health Needs Assessment (CHNA) cycle will help WellStar address persistent community health issues and ensure continuity from one Implementation Plan to the next.

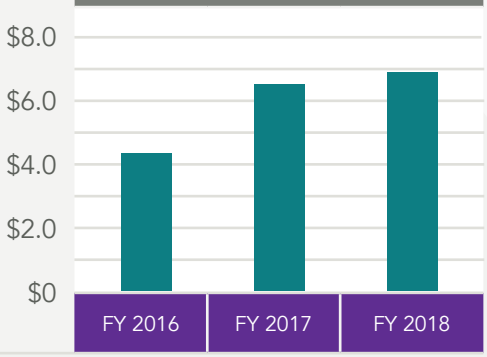
Investing in Community Benefit

Improving the health of vulnerable populations, including those with financial need, is an essential part of WellStar's Community Benefit efforts and our momentum in building a healthier community continues to grow. For the past three years, we have invested almost $2.0 billion in community benefit. This amount has increased dramatically due to our 2016 expansion. As the graph below illustrates, WellStar incurred more than $657 million in cost to provide charity care to patients. Patients who meet the criteria are deemed eligible for charity care, with no obligation to pay, according to state regulations and WellStar policy. We also provided an additional $316 million to care for those who, for various reasons, did not apply for charity care, but were unable to pay for services. Finally, our physicians and facilities made up a significant shortfall in reimbursements for patients on Medicaid ($214 million) and on Medicare ($547 million).

Community Benefit Financial Investment, 2016–2018*



Financial Investment Growth
(in millions)



* *Net Community Benefit at Cost. For reporting purposes, WellStar follows federally mandated and other guidelines for patients, including: Indigent: Patients at or below 125 percent of the federal poverty level. Charity: Patients between 125 and 300 percent of the federal poverty level. Medicaid: A federal- and state-administered program providing access to care for certain low-income and/or disabled individuals. On average, Medicaid reimburses physicians, hospitals and other providers less than the cost of care. For 2017, the U.S. Census Bureau defined the federal poverty level as $12,060 for an individual and $24,600 for a family of four.*

In the past three years, WellStar has invested approximately $25 million in community programs. We believe prevention and early detection provide the best approach to maintaining health and avoiding disease. WellStar provides health and wellness programs and services in community and worksite settings, to targeted populations, to improve the health, safety and well-being of the individuals we serve. In addition, WellStar has built a tremendous network of strategic community partnerships on behalf of WellStar to collectively impact the health status of our community.

Community Outreach and Education Impact Metrics, 2016–2018

660,932
total participants between all programs and services

193,327
students learned about important health topics through
8,050
school health programs and events

85+
partners in our Congregational Health Network

42,471
free health screenings provided

10,659
Community Health events and programs

2,700
Good Life Club members

23,163
participants in safety and injury prevention programs

Equipment distribution:

11,375
car seats

6,341
bicycle helmets

21,543
safety reflectors

Policy, System and Environmental Changes Success Stories

It is WellStar's policy to support our mission by improving the overall health and well-being of the communities we serve by focusing our Community Benefit Strategies on the priority health needs identified in the CHNA process. These strategies are executed across the entire health system and through a variety of initiatives. Every three years, the CHNA process allows for WellStar to take a systematic approach to ensuring that our resources improve the health of our communities in the most efficient way. In addition, the CHNA provides a unique opportunity for WellStar to engage community members and community-based organizations in strategy development.

Findings from the 2016 CHNA heightened WellStar's efforts to navigate the challenges of effectively linking community and clinical services to improve health outcomes in the long term. Much of WellStar's success in addressing priority health needs relied on our ability to make critical policy, systems and environmental (PSE) changes that better support our Implementation Plan. These PSE changes are centralized on our need to have a comprehensive approach – with WellStar working with internal stakeholders; local governments; community organizations; and businesses, employers and families – to implement initiatives that impact health and quality of life. These changes have also helped WellStar break down organizational silos, consolidate resources and continue our momentum toward value-based models.

PSE Success Story: Establishing the WellStar Community Benefit Department

In response to 2016 CHNA findings and the diversity of WellStar communities, a more precise shift and allocation of resources was done each year to better align strategies to address prioritized health needs. For instance, WellStar's first Community Benefit Department was established to drive initiatives and outreach that address community health needs, health equity and disparities. In addition, this Department assists with auditing services and building an infrastructure for accountability and realignment. The Community Benefit Department governs the WellStar Community Health Collaborative.

PSE Success Story: Expanding WellStar Community Health Collaborative

Community Benefit is led by the WellStar Community Health Collaborative (WCHC), a cross-functional team that represents multiple facets of WellStar Health System. In response to CHNA findings and the diversity of WellStar communities, WCHC was expanded to increase WellStar's capacity to support Community Benefit strategies. By engaging a more diverse selection of WellStar leadership and subject matter experts, Community Benefit priorities and initiatives can best reflect the capacity of the organization to impact and meet the community's needs. This expansion also helps WCHC increase coordination of efforts, leverage partnerships and maximize efficiency and strategic alignment, within and across WellStar Health System. This is done by WCHC members guiding and informing the community benefit CHNA and strategic planning process for greater institutional alignment and impact. WellStar Health System has also included community needs and community benefit programs in strategic and operational plans across the entire health system.

Expanded Representation for Strategic Alignment

PSE Success Story: Moving Upstream

Social determinants of health – where we live, work and play – have a tremendous effect on one's health and they can affect anyone, regardless of age, race or ethnicity. The American Hospital Association reported that socioeconomic factors are responsible for approximately 40 percent of a patient's health, while just 20 percent was tied to care access and quality of care.[20] Addressing social determinants of health has also been highlighted as the key to promoting good health for all. For instance, Healthy People 2020 highlights the importance of addressing the social determinants of health as one of the four overarching goals for the decade.[21] This emphasis is shared by the World Health Organization, whose Commission on Social Determinants of Health in 2008 published the report, *Closing the Gap in a Generation: Health equity through action on the social determinants of health.*[22] Finally, this emphasis is also shared by other national health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy.[23,24]

20 *American Hospital Association. Hospitals and Health Systems Addressing Social Determinants of Health. Available from: https://www.aha.org/addressing-social-determinants-health-presentation*

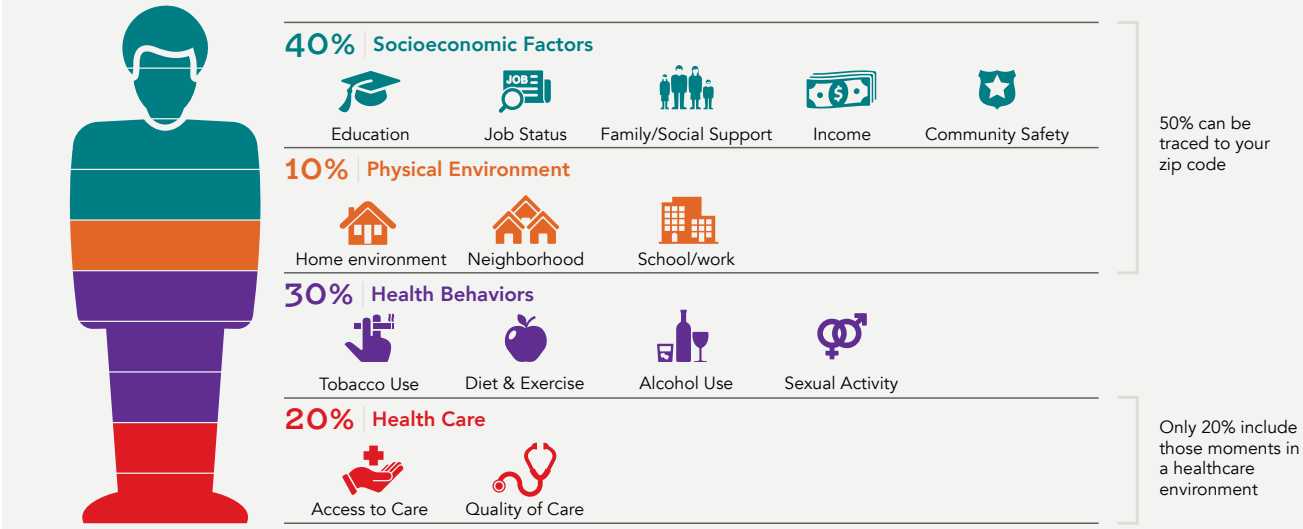
21 *Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. Healthy People 2020: An Opportunity to Address the Societal Determinants of Health in the United States. July 26, 2010. Available from: http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm*

22 *World Health Organization, Commission on Social Determinants of Health. Closing the Gap in a Generation: Health equity through action on the social determinants of health. Available from: http://www.who.int/social_determinants/enExternal Web Site Policy*

23 *National Partnership for Action: HHS Action Plan to Reduce Racial and Ethnic Health Disparities, 2011; and The National Stakeholder Strategy for Achieving Health Equity, 2011. Available from: http://minorityhealth.hhs.gov/npa*

24 *The National Prevention and Health Promotion Strategy. The National Prevention Strategy: America's Plan for Better Health and Wellness, June 2011. Available from: https://www.surgeongeneral.gov/priorities/prevention/strategy/index.html*

Social Determinants of Health



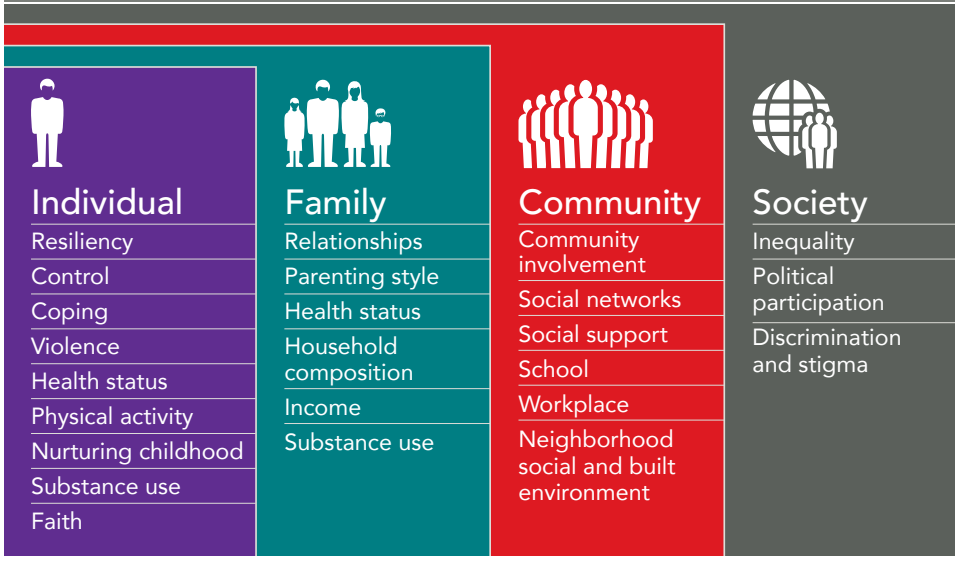
Adaption from Institute for Clinical Systems Improvement. Going Beyond Walls: Solving Complex Problems, 2014.

In addition, WellStar acknowledges that each community has different needs when addressing social determinants of health. WellStar's geographical footprint lends to communities that have various strengths and challenges when it comes to access to social and economic opportunities; the resources and supports available in homes, neighborhoods and communities; the quality of schooling; the safety of workplaces; the cleanliness of water, food and air; and the nature of social interactions and relationships. These conditions in which our communities live explain in part why some groups are healthier than others and why some groups more generally are not as healthy as they could be. This is demonstrated in the similarities and differences in the identified priority health needs in 2016.

Finally, WellStar acknowledges that there are multiple ways WellStar can address social determinants of health – both within our own walls and outside in the community.

In response to the 2016 CHNA findings, WellStar has continued to enhance our internal policies and systems to better support the individual social needs of patients and the community needs for social need support. These approaches are centered around both upstream and midstream strategies. The midstream strategies helped mitigate the acute social and economic challenges of individual patients by

Social Determinants of Health and their Impact on Health Outcomes



Health Outcomes

Mortality	Life Expectancy	Healthcare Expenditures	Health Status	Functional Limitations

Adapted from Kaiser Family Foundation. Beyond Healthcare: The Role of Social Determinants in Promoting Health and Health Equity, 2015

WellStar's Role in Addressing Social Determinants of Health

Upstream Community Impact	Engaging with the Community	Investing in the Community
	Partnering with the Community	Advocacy
Midstream Individual Impact	Screening for Social Factors such as Housing and Food Access	
	Connecting Patients to Community Resources	
	Implementing System-wide Initiatives	
Downstream	Providing Clinical Care	
	Medical Interventions	

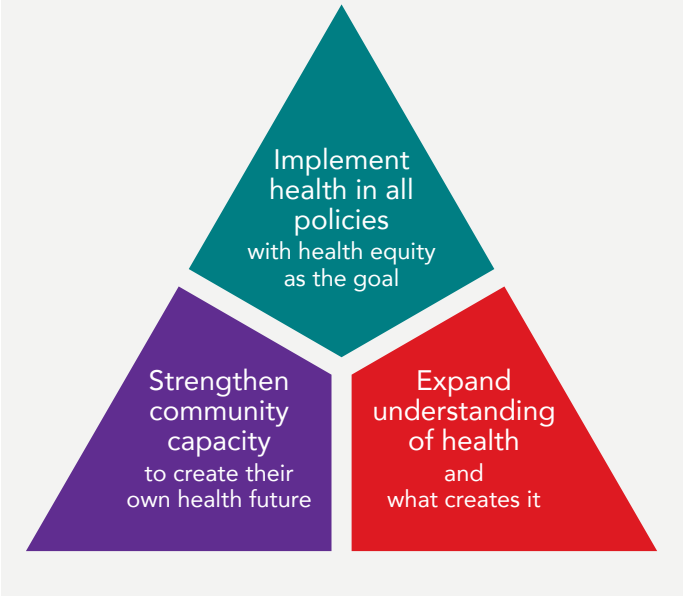
(1) screening patients for social needs; (2) connecting patients to community resources; and (3) implementing system-wide population health initiatives.[25] While targeted, small-scale social interventions provide invaluable assistance for individual patients, we also remained focused on the social determinants that perpetuate poor health at the community level. Our external processes recognized that the demand for social needs interventions will not stop until the true root causes are addressed. Our upstream strategies sought to improve community conditions by (1) engaging with the community; (2) partnering with community-based organizations; (3) investing in the community; and (4) advocacy for laws, policies and regulations that create community conditions that support health for all people. As we continue to evolve as a health system, WellStar is constantly researching public health practice models to ensure that we are aligned with evidence-based strategies. This is why our 2019 Implementation Plan has evolved to a prescribed two-prong approach that focuses on internal (midstream) and external (upstream) community benefit interventions that can work synergistically to address priority health needs.

PSE Success Story: Health Equity Pledge

Along with hundreds of hospitals and health systems across the nation, WellStar Health System signed onto the American Hospital Association's #123forEquity Pledge to Act Campaign.[26] By signing onto this campaign, WellStar is reinforcing our commitment to address the priority health needs that are identified in the 2016 and future CHNAs through a health equity lens.

The Health Equity Pledge campaign seeks to build on and accelerate the efforts of the National Call to Action to Eliminate Health Disparities launched in 2011 by the American Hospital Association and other partner organizations. This campaign focuses on increasing the collection and use of race, ethnicity and language preference data; cultural competency training; and diversity in leadership and governance. In addition, this campaign seeks to improve and advance community partnerships to help WellStar better understand the unique concerns and challenges of the populations we

ASTHO Triple Aim of Health Equity



25 *Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health. Available from: https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full*

26 *Hospitals pledge to eliminate healthcare disparities. American Hospital Association. https://www.aha.org/news/headline/2015-09-22-hospitals-pledge-eliminate-health-care-disparities*

serve. In response to 2016 CHNA findings, tenets of achieving health equity are intertwined throughout existing Community Benefit strategies and will be an integral part of future Community Benefit initiatives. These strategies and initiatives are anchored in the Association of State and Territorial Health Officials (ASTHO).

PSE Success Story and Lessons Learned: WellStar 4-1 Care

In the 2016 Implementation Plan, WellStar documented the establishment of a new initiative – WellStar 4-1 Care. This program relied considerably on the need to change both internal and external processes through formalized partnership agreements between WellStar and the partnering community clinic. To date, WellStar has established a dynamic partnership with CareLink of Northwest Georgia Community Clinic, which serves members of Paulding County. CareLink is a 501(c)(3) nonprofit organization governed by engaged citizens, business owners, healthcare professionals and members of the faith-based community in Paulding. Results of the most recent CHNA for Paulding County commanded a deliberate focus on Prevention and Access to Care. In Paulding County, 18 percent of residents are uninsured limiting their ability to obtain crucial preventive and routine health services. This statistic is most profoundly manifested in Paulding's elevated rates of chronic disease and preventable illness with heart disease, lung disease, cancer and stroke at the top of the list. In partnership with WellStar Health System; CareLink was created to provide healthcare and other necessary resources to our county's uninsured and underserved residents. We are confident that through the provision of safe and compassionate high-quality care, CareLink will effectively strengthen individuals, families and the Paulding community at large enabling all residents to live a happier, healthier lifestyle.

Some of the matters that have impacted our completing more formalized partnerships with community clinics include (1) community clinics are currently in negotiation with WellStar to clearly identify roles and responsibilities to establish a formalized memorandum of understanding; (2) targeted community clinic's financial and time commitments outweigh potential benefits of establishing 4-1 Care at their site at this time; and (3) targeted community clinics are no longer open or have considerable operational challenges to establish WellStar 4-1 care at their site.

In the 2019 Implementation Plan, WellStar has carried over the WellStar 4-1 to grow as a Community Benefit initiative. We will continue to navigate the complexities of establishing a formalized memorandum of understanding between the health system and community clinics. We are also looking forward to using the lessons learned to expedite the agreement process. WellStar recognizes that community clinics are a key component of our healthcare system, providing essential access to comprehensive primary care in underserved communities.

Lessons Learned: Live Well

In 2016, WellStar documented in our Implementation Plan the establishment of a new initiative – Live Well. Live Well was a health education initiative that sought to offer chronic disease management and healthy lifestyle education at local community worksites and community clinics. This initiative was launched while WellStar was systematically diffusing other health education programs and initiatives across WellStar's growing geographical footprint. During the same time, the Community Benefit Department was created. The latter two occurrences created an opportunity for WellStar to have a greater impact in all the communities we serve. Therefore, the Live Well strategy was circumvented to more effectively rely on existing infrastructures, capacities and resources. Through this transition, the importance of strategically aligning future Community Benefit efforts was reinforced as the newly created Community Benefit Department works to optimize WellStar's existing assets.

Today, our current health education offerings encapsulate the essence of Live Well, which is centered on promoting wellness within the community, including chronic disease awareness and prevention; maternal and infant health; tobacco use and substance abuse; injury and violence prevention; mental and behavioral health; and nutrition, exercise and obesity prevention. In addition, WellStar's health education offerings continue to seek out and leverage opportunities to increase access to culturally appropriate health education for communities that are in greatest need of resources and support.

Lessons Learned: Evaluation and Impact Reporting

WellStar Health System tracks, monitors and reports our Community Benefit investment to transparently share how we address the needs of our community. To assist with this process, WellStar utilizes Community Benefit Inventory for Social Accountability (CBISA) and internal tracking systems. To date, a considerable amount of tracking and monitoring has focused on productivity, performance and investment metrics. These metrics help WellStar create a snapshot of our efforts and help us understand what our health system has accomplished and is capable of. In addition, these metrics inform important benchmarks for strategic planning.

However, we recognize that continued process improvements are needed to better evaluate and monitor our impact. Establishing a stronger evaluation and monitoring system will enhance WellStar's ability to innovate and align with the ideas, networks, resources, capacity and interests of our diverse partners when struggling through complex community health issues, intervention options and implementation decisions. In addition, this will create opportunities to share leading practices that will be critical in helping WellStar make the most of our community health efforts. In 2019, WellStar's Community Benefit Department is researching how to increase our internal data and monitoring capacity through new internal resources and key external partnerships.

Appendix

Consultant Qualifications

The Georgia Health Policy Center (GHPC), housed within Georgia State University's Andrew Young School of Policy Studies, provides evidence-based research, program development, and policy guidance locally, statewide and nationally to improve communities' health status. With more than 21 years of service, GHPC focuses on solutions to the toughest issues facing healthcare today, including insurance coverage, long-term care, children's health and the development of rural and urban health systems.

GHPC draws on more than a decade of combined CHNA learnings from its experience with 100-plus projects supported by 75 diverse funders. The studies span the layers of the socioecological model and include individual, multisite and meta-level assessments of communities, programmatic activities and provision of technical assistance.

GHPC has guided a national expert team in the design of the Federal Office of Rural Health Policy's Network and Outreach Program evaluations, been commissioned by communities as external evaluators and conducted assessments and community engagements that include the following:

- GHPC conducted a regional community health needs assessment process to meet the IRS regulations of Schedule H, which included 29 Georgia counties and metro Atlanta between 2015 and 2016. Partners included Grady Health System, Piedmont Healthcare, WellStar, Mercy Care and Kaiser Foundation Health Plan of Georgia (KFHPGA).
- The regional assessment project served as the foundation for the community health improvement planning process employed by GHPC to generate the Implementation Plan in partnership with Grady Health System and KFHPGA. GHPC has conducted similar assessments and plans to address needs for Grady Health System and KFHPGA in 2009 and 2013.
- GHPC managed the community engagement and conducted the county-level CHNA for which the results will serve as the foundation for Clayton County Board of Health's application to the Public Health Accreditation Board (PHAB) for accreditation. GHPC remains engaged as Clayton County prepares for the next stages of accreditation.
- GHPC evaluated seven metro Atlanta counties to measure the demand on and capacity of the urban health care "safety net." The study addresses the issue of shrinking access for those who face the most significant barriers to health care and examines the health needs and safety-net services in Fulton, DeKalb, Cobb, Forsyth, Gwinnett and Henry counties. The project is funded by a grant from the KFHPGA through the Community Foundation of Greater Atlanta.
- GHPC conducted an assessment of Georgia's public health system to more clearly define public health's "core business" related to the broader system of health and health care in the state, gain an accurate understanding of the public's perception of the role of public health, examine the areas of existing service overlap, and investigate opportunities for increased collaboration with various health care providers and stakeholders.

Secondary Data

(July 2018–November 2018)

County Health Rankings† (2018)	
Bartow	42
Carroll	74
Cherokee	3
Cobb	7
DeKalb	18
Douglas	26
Fulton	14
Paulding	9

Age Distribution

	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding
0-14	20.00%	19.70%	20.00%	19.90%	20.40%	20.60%	19.00%	21.00%
15-17	4.40%	4.30%	4.50%	4.10%	3.60%	4.80%	3.90%	4.80%
18-24	9.10%	12.30%	9.10%	9.30%	8.50%	10.00%	10.10%	9.60%
25-34	12.60%	13.40%	11.60%	13.70%	15.60%	12.40%	15.30%	12.60%
35-54	26.90%	25.10%	28.70%	28.80%	28.30%	28.60%	28.50%	29.50%
55-64	12.70%	11.50%	12.70%	12.20%	11.80%	12.10%	11.60%	11.50%
65+	14.30%	13.60%	13.50%	12.00%	11.70%	11.50%	11.60%	11.20%

Racial Distribution

	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding
White	77.70%	70.40%	77.90%	50.80%	29.40%	43.30%	39.70%	72.50%
Black	10.70%	19.30%	7.10%	27.60%	52.10%	43.20%	42.10%	17.70%
Hispanic‡	8.50%	6.70%	10.50%	13.20%	9.40%	9.00%	7.60%	6.30%
Asian	1.00%	1.20%	2.10%	5.40%	6.60%	1.60%	8.10%	1.10%
All Others	2.10%	2.50%	2.40%	3.00%	2.40%	3.00%	2.50%	2.40%

County Health Rankings and Roadmaps: countyhealthrankings.org

Demographics Expert 2.7, 2018 Demographic Snapshot

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Socioeconomic

	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding	Georgia	U.S.
On-time high school graduation (2014-15)	80.4%	84.3%	80.7%	86.0%	71.8%	88.0%	72.6%	80.0%	80.0%	88.2%
Free and reduced price lunch (2014-15)	58.0%	61.8%	45.6%	8.4%	69.0%	61.7%	ND	41.6%	62.4%	52.6%
Unemployment rate (2017)	4.1%	4.5%	3.7%	3.4%	4.4%	4.5%	4.4%	3.8%	4.3%	4.0%
Population below 100% FPL (2012-16)	14.8%	19.3%	11.6%	10.0%	19.0%	15.2%	17.0%	10.7%	17.8%	15.7%
Children below 100% FPL (2012-16)	19.1%	26.0%	16.5%	13.8%	30.1%	21.2%	24.7%	14.2%	25.4%	23.6%
Adults with no high school diploma (2012-16)	18.4%	18.9%	8.8%	10.2%	11.4%	11.7%	8.7%	10.4%	14.2%	38.4%
Uninsured population (2012-16)	15.6%	15.5%	15.4%	13.3%	17.2%	15.6%	13.7%	12.5%	15.8%	11.8%

Healthcare Access

	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding	Georgia	U.S.
Primary care providers* (2014)	45.2	45.6	69.2	35.5	106.3	42.5	105.5	14.1	72.9	87.8
Dentists* (2015)	31.1	29.7	65.4	48.7	56.6	41.9	68.4	15.8	49.2	65.6
Mental health providers* (2016)	97.3	88.2	130.6	79.7	247.0	68.2	191.2	30.9	115.0	200.7
Recent primary care visit (2014)	86.0%	79.8%	ND	82.9%	76.6%	82.8%	76.3%	83.3%	81.0%	78.9%
Federally Qualified Health Centers* (2016)	100.0%	90.0%	90.0%	90.0%	190.0%	0.0%	130.0%	0.0%	2.09	2.4
Health Professional Shortage Area - Dental (2016)	100.0%	0.0%	0.0%	0.0%	0.0%	53.0%	9.9%	0.0%	37.9%	37.8%
Uninsured population (2012-16)	13.3%	15.4%	13.4%	17.2%	9.9%	13.7%	18.3%	12.7%	15.8%	11.8%

Health Determinants

	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding	Georgia	U.S.
Current smokers (2015)	17.2%	17.7%	14.9%	15.1%	16.1%	17.6%	16.0%	15.3%	17.0%	15.7%
Health food stores (low access) (2014)	29.2%	51.2%	40.2%	42.7%	23.4%	42.6%	ND	48.4%	30.8%	22.4%
Exercise opportunities - access (2010/2014)	81.5%	62.1%	88.8%	79.7%	96.2%	76.1%	ND	75.1%	75.9%	84.3%
Driving alone to work, long distances (>60 mins) (2012-16)	42.6%	36.9%	51.3%	55.8%	48.8%	52.6%	37.9%	60.6%	40.0%	34.8%

Clinical Care & Prevention

	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding	Georgia	U.S.
SNAP Benefits (2012-2016)	15.5%	20.1%	9.3%	7.1%	15.8%	15.7%	13.3%	11.6%	15.3%	19.1%
Physical inactivity – adults (2013)	25.0%	28.0%	18.4%	19.7%	20.2%	26.1%	18.0%	24.1%	23.1%	21.7%
Preventable hospital events* (2014)	67.5	34.2	52.0	55.6	38.6	62.5	40.5	67.8	52.3	50.4
Teen births* (2008-14)	45.1	40.8	3.8	21.5	38.1	32.5	34.6	21.7	38.5	32.1

Other Health Indicators

	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding	Georgia	U.S.
Population with any disability (2012-16)	14.8%	15.7%	8.5%	9.4%	10.2%	12.0%	9.9%	10.3%	12.4%	12.6%
Impaired driving deaths (2011-2015)	17.7%	25.3%	24.8%	18.8%	22.4%	29.2%	22.8%	10.9%	23.4%	†
Poor physical health days (2015)	3.8	4.0	3.5	3.4	3.7	3.9	3.4	3.5	3.9	3.7
Poor mental health days (2015)	3.7	4.0	3.4	3.5	3.7	3.7	3.6	3.5	3.8	3.7
Stroke prevalence (2015)	4.6%	4.2%	4.3%	4.5%	4.6%	4.5%	4.0%	4.4%	4.2%	4.0%
Age-adjusted drug overdoses (2007)	7.8	21.5	11.2	6.2	6.0	7.3	10.9	14.5	8.6	†
Age-adjusted drug overdoses (2017)	25.8	27.5	16.7	18.1	10.2	16.0	14.5	15.5	14.6	†
Years of potential life lost (YPLL75) (2017)	7,881.0	10,469.5	40,761.0	13,053.0	51,725.5	95,17.5	63,386.0	10,770.0	763,397.0	†
Mental health ER rate* (2017)	1,502.1	1,353.0	965.1	864.4	1,015.7	1,314.3	1,502.4	1,194.1	1,094.6	†
Mental and behavioral disorder mortality (2013-17)*	34.8	30.1	29.5	31.4	34.3	34.0	33.3	19.0	37.4	†
Self-harm age-adjusted discharge rate* (2013-17)	54.3	36.8	30.4	27.5	28.2	28.1	25.4	37.5	32.7	†
Age-adjusted suicide mortality (2013-17)*	17.5	16.9	11.5	14.4	7.9	10.7	10.4	13.6	12.7	†
Age-adjusted opioid overdoses (2007)	ND	11.9	1.0	6.3	2.7	ND	4.5	5.6	3.4	†
Age-adjusted opioid overdoses (2017)	18.0	18.2	14.7	15.1	6.3	13.2	9.3	12.2	9.7	†
Assault age-adjusted discharge rate (2013-17)	10.0	11.8	10.0	5.3	36.4	9.8	42.6	6.5	18.6	†
Diagnosed diabetes-prevalence (2013)	12.1%	11.3%	8.5%	8.7%	10.0%	12.0%	8.7%	11.0%	10.6%	9.2%

Other Health Indicators (continued)										
	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding	Georgia	U.S.
Diabetes age-adjusted discharge rate (2013-17)	229.4	153.8	103.1	147.1	219.7	214.4	186.6	163.1	188.1	†
Diabetes age-adjusted mortality rate (2013-17)	13.8	28.4	14.2	13.0	21.0	23.3	17.5	13.3	21.7	†
Adults obesity (2014)	34.2%	32.9%	25.1%	27.5%	27.2%	32.0%	25.8%	29.0%	30.0%	†
Obs. Heart disease/ heart attack age-adjusted discharge rate* (2013-17)	442.5	401.3	180.0	224.2	205.7	255.7	195.3	303.6	265.0	†
Hypertensive heart disease age-adjusted discharge rate* (2013-17)	77.7	54.1	28.4	27.9	47.2	43.8	47.8	45.4	39.0	†
Asthma ER visit rate* (2017)	468.3	495.7	461.9	263.0	727.9	792.3	738.8	531.2	525.5	†
Motor vehicle crash age-adjusted er visit rate* (2013-17)	1,170.5	1,548.0	972.7	830.7	1,008.8	1,581.2	898.0	1,388.6	1,099.9	†
HIV prevalence rate (2015)	188.3	182.4	436.4	140.9	1,167.3	337.9	1,599.2	123.4	588.0	†
HIV new diagnosis (2016)	7.0	14.5	29.9	9.0	66.0	10.3	75.6	9.5	30.7	†
Age-adjusted STD rate except congenital syphilis (2017)	708.4	693.4	716.1	399.5	1,310.3	881.9	1,398.8	472.1	890.4	†
% Low birth weight (< 2500g) (2013-17)	8.1%	8.2%	8.7%	6.9%	10.0%	9.5%	10.7%	7.4%	9.6%	†
Infant mortality rate – total (2013-17)	6.5	6.2	6.5	4.6	7.6	6.5	7.0	6.5	7.5	†
Infant mortality rate – non-Hispanic White (2013-17)	4.9	5.6	4.6	3.9	3.9	5.7	3.3	4.3	5.4	†
Infant mortality rate – Black (2013-17)	15.3	8.6	11.0	9.0	11.5	8.1	10.9	11.0	12.2	†

ND for rates: Rates based on 1-4 events are not shown, ND for data: unavailable due to a lack of data reporting or data suppression
Center for Disease Control and Prevention: www.cdc.gov/diabetes/data/countydata/countydataindicators.html
Kaiser Permanente CHNA Data Platform: kp-chna.ip3app.org
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us
Center for Disease Control and Prevention - NCHHSTP Atlas Plus: www.cdc.gov/nchhstp/atlas/index.htm
Community Commons CHNA Portal: CHNA.org

* *Per 100,000 population*

† *This data set includes Georgia data, and does not include an equivalent data set for the U.S.*

2017–2018 Community Need Index (CNI) – WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill Hospitals

Zip Code	County	Change (2017-18)	2015 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/kids	Income Score	Limited English	Minority	Culture Score	No High School Diploma	Education Score	Unemployed	Uninsured	Insurance Score	Renting	Housing Score
30008	Cobb	-0.2	4.6	8.8%	28.0%	40.8%	3.0	10.4%	78.0%	5	22.5%	5.0	9.9%	17.7%	5.0	44.3%	5.0
30060	Cobb	0.0	4.8	11.1%	32.1%	47.8%	4.0	15.7%	70.1%	5	27.1%	5.0	9.0%	18.8%	5.0	52.8%	5.0
30062	Cobb	0.0	2.4	5.3%	5.2%	19.5%	1.0	3.5%	32.6%	4	5.7%	1.0	4.3%	6.9%	3.0	20.3%	3.0
30064	Cobb	-0.2	2.6	11.9%	7.1%	18.0%	1.0	3.0%	38.1%	4	7.3%	2.0	5.9%	8.6%	3.0	20.2%	3.0
30066	Cobb	0.0	2.4	5.9%	6.8%	17.5%	1.0	1.8%	32.2%	4	4.0%	1.0	5.3%	6.7%	3.0	20.2%	3.0
30067	Cobb	0.2	4.4	8.1%	22.1%	46.1%	4.0	6.7%	56.6%	5	9.4%	3.0	7.3%	15.0%	5.0	58.7%	5.0
30068	Cobb	0.0	2.2	5.1%	5.4%	18.2%	1.0	1.9%	23.6%	4	2.8%	1.0	4.9%	6.2%	3.0	18.0%	2.0
30080	Cobb	0.0	4.0	12.2%	22.0%	34.5%	3.0	6.3%	58.4%	5	11.9%	3.0	5.7%	12.1%	4.0	57.3%	5.0
30082	Cobb	-0.2	3.6	18.1%	17.1%	22.4%	2.0	6.1%	52.0%	5	9.8%	3.0	6.6%	10.8%	4.0	34.1%	4.0
30101	Cobb	-0.2	2.4	7.0%	7.9%	18.2%	1.0	2.2%	33.3%	4	6.8%	2.0	6.3%	7.9%	3.0	18.1%	2.0
30102	Cherokee	-0.4	3.0	6.7%	10.9%	18.2%	1.0	2.7%	32.7%	4	12.3%	3.0	6.3%	10.9%	4.0	21.3%	3.0
30106	Cobb	0.0	4.2	12.8%	25.7%	39.1%	3.0	2.6%	72.6%	5	12.1%	3.0	8.0%	16.2%	5.0	37.0%	5.0
30114	Cherokee	0.2	3.8	11.7%	15.0%	39.1%	3.0	3.8%	24.1%	4	13.1%	4.0	3.7%	13.6%	4.0	27.7%	4.0
30115	Cherokee	0.0	2.6	6.2%	12.1%	38.0%	3.0	2.2%	15.8%	3	8.4%	2.0	5.4%	8.6%	3.0	16.1%	2.0
30122	Douglas	0.0	4.2	10.1%	23.0%	35.2%	3.0	2.0%	71.4%	5	10.1%	3.0	11.0%	15.0%	5.0	50.3%	5.0
30126	Cobb	0.0	3.4	14.3%	14.8%	31.1%	2.0	5.4%	63.9%	5	11.5%	3.0	5.6%	11.1%	4.0	22.7%	3.0
30127	Cobb	0.2	2.6	9.6%	8.1%	14.7%	1.0	2.0%	54.5%	5	9.5%	3.0	6.7%	8.1%	3.0	12.5%	1.0
30132	Paulding	0.0	3.2	15.0%	10.9%	31.3%	2.0	1.1%	26.2%	4	10.2%	3.0	5.3%	9.0%	4.0	20.3%	3.0
30134	Douglas	-0.2	4.2	13.6%	22.3%	40.4%	3.0	2.3%	56.5%	5	14.5%	4.0	7.8%	19.1%	5.0	30.6%	4.0
30135	Douglas	0.0	3.0	6.0%	11.9%	26.1%	2.0	1.7%	55.2%	5	9.2%	2.0	8.3%	10.9%	4.0	19.6%	2.0
30141	Paulding	-0.2	3.0	13.5%	9.0%	18.0%	1.0	0.8%	33.1%	4	10.4%	3.0	5.5%	11.3%	4.0	20.8%	3.0
30144	Cobb	0.2	3.4	5.6%	9.8%	15.9%	1.0	2.1%	44.5%	5	6.5%	2.0	6.3%	9.9%	4.0	38.2%	5.0
30152	Cobb	0.0	2.6	8.2%	6.4%	18.1%	1.0	3.1%	37.4%	4	6.9%	2.0	5.7%	6.7%	3.0	23.1%	3.0
30157	Paulding	-0.4	2.8	15.2%	10.5%	30.6%	2.0	0.7%	25.8%	4	10.3%	3.0	5.3%	8.7%	3.0	19.5%	2.0
30168	Cobb	0.2	4.8	15.5%	31.7%	43.5%	4.0	9.1%	88.6%	5	21.8%	5.0	10.6%	19.6%	5.0	50.6%	5.0
30180	Carroll	-0.2	3.6	10.3%	16.6%	38.4%	3.0	0.8%	35.6%	4	12.1%	3.0	8.6%	13.6%	4.0	25.6%	4.0
30188	Cherokee	0.0	2.6	11.1%	11.1%	33.0%	2.0	2.9%	24.0%	4	6.0%	1.0	4.2%	9.2%	4.0	19.6%	2.0
30189	Cherokee	0.0	2.4	4.6%	10.0%	14.2%	1.0	4.1%	20.8%	4	6.1%	1.0	4.3%	8.6%	3.0	20.6%	3.0
Bartow Total		**0.1**	**3.8**	**9.8%**	**17.0%**	**43.4%**	**3.5**	**1.7%**	**22.3%**	**4**	**17.1%**	**4.1**	**5.2%**	**12.2%**	**4.0**	**30.2%**	**3.8**
Carroll Total		**-0.1**	**4.0**	**13.2%**	**21.8%**	**47.0%**	**3.6**	**1.3%**	**29.6%**	**4**	**16.8%**	**4.2**	**9.7%**	**18.0%**	**4.7**	**31.2%**	**3.9**
Cherokee Total		**0.0**	**2.9**	**8.2%**	**12.3%**	**31.7%**	**2.2**	**2.9%**	**22.1%**	**4**	**9.4%**	**2.3**	**4.6%**	**10.3%**	**3.7**	**20.7%**	**2.6**
Cobb Total		**0.0**	**3.2**	**9.2%**	**13.4%**	**25.4%**	**1.8**	**4.5%**	**49.2%**	**5**	**9.7%**	**2.5**	**6.3%**	**10.4%**	**3.7**	**32.4%**	**3.5**
DeKalb Total		**-0.1**	**3.9**	**12.5%**	**20.6%**	**35.3%**	**3.0**	**5.6%**	**70.6%**	**5**	**12.2%**	**3.0**	**8.6%**	**14.6%**	**4.3**	**42.5%**	**4.5**
Douglas Total		**-0.1**	**3.6**	**8.9%**	**16.9%**	**32.5%**	**2.5**	**1.9%**	**56.7%**	**5**	**11.1%**	**2.9**	**8.5%**	**14.0%**	**4.5**	**27.9%**	**3.1**
Fulton Total		**0.0**	**3.6**	**11.6%**	**19.1%**	**35.1%**	**2.8**	**2.3%**	**60.3%**	**5**	**8.6%**	**2.2**	**7.7%**	**16.1%**	**3.8**	**44.8%**	**4.5**
Paulding Total		**-0.2**	**3.0**	**14.8%**	**10.3%**	**28.1%**	**1.8**	**0.8%**	**27.5%**	**4**	**10.3%**	**3.0**	**5.4%**	**9.4%**	**3.6**	**20.0%**	**2.6**

Racial/Ethnic Disparities by County

	Bartow	Carroll	Cobb	Cherokee	DeKalb	Douglas	Fulton	Paulding	Georgia	U.S.
% Uninsured population (2012-16)	15.60%	15.50%	13.30%	15.40%	17.20%	15.60%	13.70%	12.50%	15.80%	11.70%
Annual cervical cancer incidence rate (2011-15) *	11.80	7.40	6.40	6.00	6.70	8.60	6.90	8.00	7.80	7.50
Breast cancer incidence (2011-15)*	118.70	120.00	123.20	135.20	136.00	130.80	132.10	122.00	125.20	124.70
Annual colon and rectum cancer incidence rate (2011-15) *	49.60	48.70	37.00	40.20	40.60	42.30	38.10	44.20	41.80	39.20
Annual prostate cancer incidence rate (2011-15) *	97.30	107.30	114.90	131.70	143.90	129.90	143.80	113.60	123.30	109.00
Annual lung cancer incidence rate (2011-15) *	80.50	82.50	66.00	57.10	51.20	68.30	51.20	75.60	64.90	60.2
Coronary heart disease mortality, age-adjusted death rate (2012-16) *	84.60	89.00	53.90	51.90	55.00	50.20	61.10	55.60	79.10	99.60
Infant mortality rate***	6.50	6.20	4.60	6.50	7.60	6.40	7.00	6.20	7.50	ND
Adult asthma discharge rate	91.90	34.80	57.70	77.30	123.10	99.70	103.60	82.90	87.50	ND
Adult asthma ED visit rate*	495.90	543.20	267.10	499.90	738.60	831.60	651.90	549.40	551.60	ND
Stroke mortality, age-adjusted death rate*	47.30	48.90	39.80	44.00	40.50	44.20	39.20	42.20	43.0	ND
Breast cancer, age-adjusted mortality rate*	9.60	14.80	10.30	11.90	13.50	15.30	13.40	13.60	12.30	ND
Diabetes age-adjusted discharge rate*	229.40	153.80	103.10	147.10	219.70	214.40	186.60	163.10	188.10	ND
Diabetes age-adjusted mortality*	13.80	28.40	13.00	14.20	21.00	23.30	17.50	13.30	21.70	ND
Obstructive heart disease/heart attack age-adjusted discharge rate*	442.50	401.30	224.20	180.00	205.70	255.70	195.30	303.60	265.00	ND
Obstructive heart disease age-adjusted mortality*	88.60	87.20	56.50	51.40	53.20	57.20	56.30	63.50	76.40	ND
Hypertensive heart disease age-adjusted discharge rate*	77.70	54.10	27.90	28.40	47.20	43.80	47.80	45.40	39.00	ND
Hypertensive heart disease age-adjusted mortality*	26.00	20.60	15.30	7.60	14.90	5.90	24.40	21.90	16.20	ND
Cancer mortality, age-adjusted death rate*	170.30	189.60	148.00	143.50	150.10	172.40	144.60	169.60	160.70	ND

Community Commons CHNA Portal: CHNA.org

Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

ND for rates: Rates based on 1-4 events are not shown

* *Per 100,000 population*

*** *Per 1,000 live births*

Racial/Ethnic Disparities (continued)				
	White**	Black**	Asian**	Hispanic‡ **
% Uninsured population (2012-16)	9.00%	17.30%	13.70%	38.50%
Annual cervical cancer incidence rate (2011-15) *	ND	ND	ND	ND
Breast cancer incidence (2011-15)*	ND	ND	ND	ND
Annual colon and rectum cancer incidence rate (2011-15) *	38.20	45.90	29.10	29.60
Annual prostate cancer incidence rate (2011-15) *	112.20	192.00	45.40	93.00
Annual lung cancer incidence rate (2011-15) *	60.10	55.90	23.60	37.10
Coronary heart disease mortality, age-adjusted death rate (2012-16) *	58.30	62.00	34.70	19.70
Infant mortality rate***	4.30	11.00	3.30	5.30
Adult asthma discharge rate	58.10	155.20	19.20	ND
Adult asthma ED visit rate*	255.40	1,140.90	98.80	ND
Stroke mortality, age-adjusted death rate*	37.00	51.70	30.00	ND
Breast cancer, age-adjusted mortality rate*	10.30	19.00	4.80	ND
Diabetes age-adjusted discharge rate*	105.30	310.70	32.70	ND
Diabetes age-adjusted mortality*	12.00	31.90	10.40	7.30
Obstructive heart disease/heart attack age-adjusted discharge rate*	208.60	235.30	86.20	ND
Obstructive heart disease age-adjusted mortality*	57.20	62.70	31.20	22.10
Hypertensive heart disease age-adjusted discharge rate*	27.80	70.10	10.30	ND
Hypertensive heart disease age-adjusted mortality*	12.60	28.10	7.20	4.10
Cancer mortality, age-adjusted death rate*	144.30	173.20	77.60	ND

Community Commons CHNA Portal: CHNA.org

Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

ND for rates: Rates based on 1-4 events are not shown

* *Per 100,000 population*

** *Eight-County Aggregate*

*** *Per 1,000 live births*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

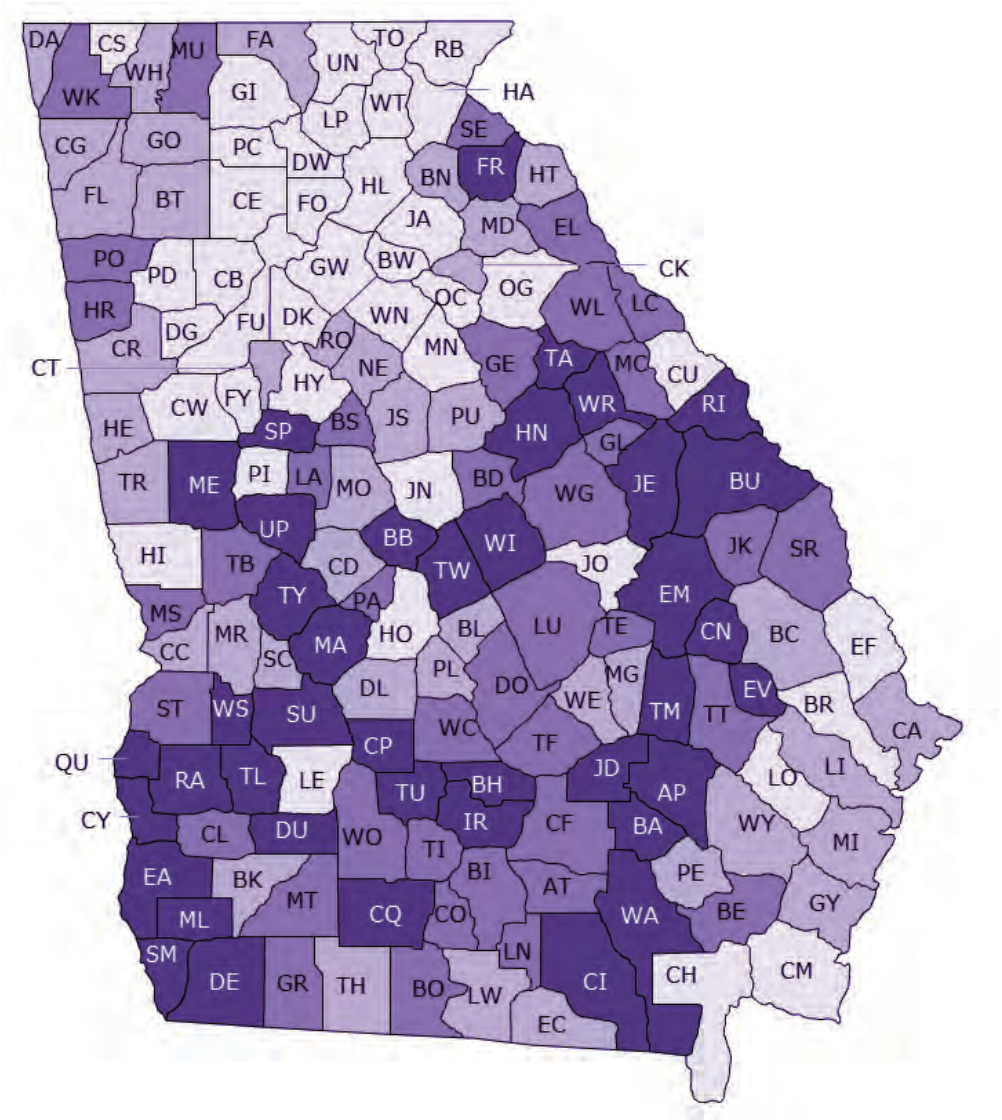
5-Hospital Service Area's Ranked Causes: Age-Adjusted Death Rate, State and County Comparison (2013-2017)					
	All Races	White	Black	Asian	Georgia
Prioritized	All Other Diseases of the Nervous System (2,487) Accidental Poisoning and Exposure to Noxious Substances (2,163) Assault (Homicide) (1,324) Human Immunodeficiency Virus (HIV) Disease (730)	Accidental Poisoning and Exposure to Noxious Substances (1,629)	Assault (Homicide) (1,075) Malignant Neoplasm of the Breast (932) Accidental Poisoning and Exposure to Noxious Substances (511) Falls (194)	Malignant Neoplasm of Pancreas (41)	ND
#1	Ischemic Heart and Vascular Disease (8,767)	Ischemic Heart and Vascular Disease (5,579)	Ischemic Heart and Vascular Disease (3,022)	Ischemic Heart and Vascular Disease (136)	Ischemic Heart and Vascular Disease (41,242)
#2	Cerebrovascular Disease (5,498)	Malignant Neoplasms of the Trachea, Bronchus and Lung (3,421)	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease (2,371)	Cerebrovascular Disease (113)	Malignant Neoplasms of the Trachea, Bronchus and Lung (22,349)
#3	Malignant Neoplasms of the Trachea, Bronchus and Lung (5,167)	All COPD Except Asthma (3,412)	Cerebrovascular Disease (2,063)	Malignant Neoplasms of the Trachea, Bronchus and Lung (71)	All COPD Except Asthma (22,123)
#4	All Other Mental and Behavioral Disorders (4,600)	Cerebrovascular Disease (3,305)	Malignant Neoplasms of the Trachea, Bronchus and Lung (1,664)	Malignant Neoplasms of Colon, Rectum and Anus (45)	Cerebrovascular Disease (20,481)
#5	All COPD Except Asthma (4,337)	All Other Mental and Behavioral Disorders (3,226)	Diabetes Mellitus (1,403)	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease (45)	All Other Mental and Behavioral Disorders (17,375)

Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us
This tool does not report data by ethnicity. As a result, there are not comparable data reported for Hispanic or Latino death rates.
ND: This data set uses Georgia rates at the benchmark for significance. As a result, comparison and prioritization of Georgia rates is not possible.

Maps

Health Outcomes

The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.

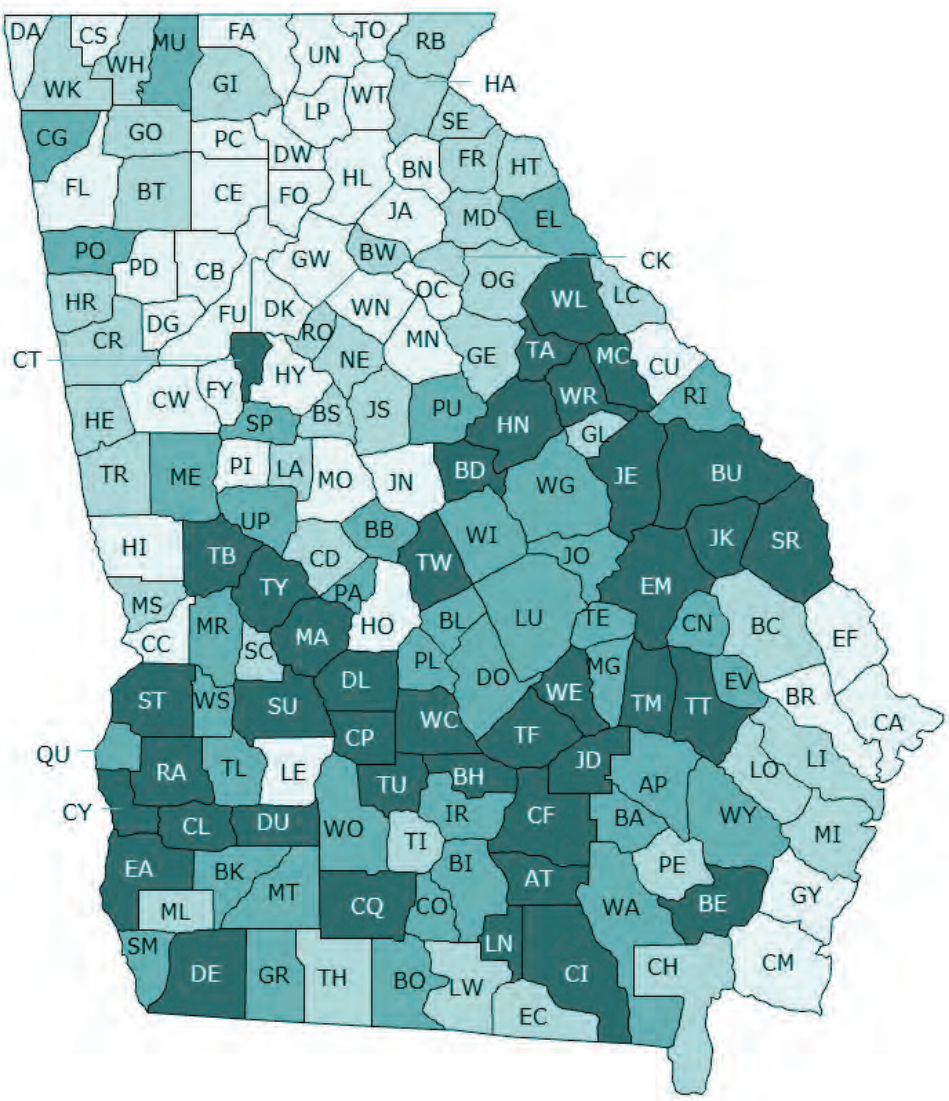


	Rank
	1-40
	41-80
	81-119
	129-159

http://www.countyhealthrankings.org/app/georgia/2018/overview

Health Factors

The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.



Rank
1-40
41-80
81-119
129-159

Primary Data and Community Input

Regional Health Board Listening Sessions, Community Health Summit, Key Informant Interviews and Focus Groups

CHNA Collaborators

Collaborator	Areas of Service
A.L. Burrus Institute for Public Service & Research Kelleigh Trepanier, *Associate Director*	Key Informant
Ajay North America	Listening Session
Austell Community Task Force DeBorah Johnson, *Chairman and President*	Key Informant Summit Participant
Bethesda Community Clinic Karen Fegely, *Chief Executive Officer*	Summit Participant
Cobb & Douglas Community Services Board Jamie Allison, *Chief Quality Officer* Lauren Baird, *Director of Specialty Services* Emily Lawery, *Director of Child and Adolescent Services*	Key Informant
Cobb & Douglas Public Health Lisa Crossman, *Deputy Director* Rachel Franklin, *Director of Epidemiology* Shannen Galvin, *Planning & Partnership Specialist* Jacqueline Dow, *Planning & Partnership Director* Rachel Franklin, *Director of Epidemiology* Janet Memark, *District Health Director*	Summit Participant
Cobb Chamber of Commerce Slade Gulledge, *Vice President, Advocacy and Government Relations*	Summit Participant
Cobb County Fire and Emergency Services Spencer Miller, *EMS Operations Division Chief*	Listening Session Summit Participant
Cobb Douglas Public Health Lisa Crossman, *Deputy Director* Rachel Franklin, *Epidemiology Director*	Key Informant

Collaborator	Areas of Service
Cobb Moms Helping Cobb Danielle Musolf, *Director*	Listening Session Summit Participant
Cobb Senior Services Amy Woodell, *Coordinator*	Summit Participant
Connecting Generations Arlene Williams, *Executive Director*	Summit Participant
Denim & Diamonds of DC, John Bleakley Ford Stephanie Bleakley, *President/ Community Relations*	Listening Session Summit Participant
Douglas County Chamber of Commerce	Listening Session
First Presbyterian Church of Douglasville James Harper, *Senior Pastor*	Summit Participant
Good Samaritan Health Center Cyrl Kitchens, *CEO*	Key Informant
Gwinnett, Newton and Rockdale County Health Departments Tara Echols, *Performance Management & Community Health Director*	Key Informant
John Bleakley Ford	Listening Session
Manager HR/General Services Sidney Miller, *Manager HR/General Services*	Summit Participant
Marietta Police Department	Listening Session
Metro Atlanta Ambulance Service	Listening Session
Mopdog Cheryl Musial, *CSO*	Listening Session Summit Participant
Morehouse School of Medicine Carmen Hughes, *Director - HIT Division*	Summit Participant

Collaborator	Areas of Service
MUST Ministries Falecia Stewart, *Senior Director*	Key Informant
Northwest Georgia Public Health District 1-1 Unini Odama, M.D.	Summit Participant
Paulding Quick Bail	Listening Session
Presbyterian Church in America	Listening Session
Professional Mojo Marketing	Listening Session
Puckett EMS Jim McMichen, *Dir of Marketing & Corp Comm*	Listening Session Summit Participant
Realtor, Atlanta Communities	Listening Session
Ser Familia, Inc Belisa Urbina, *Executive Director*	Listening Session Summit Participant
Social Security Administration Tommy Morris, *Retired Area Director*	Summit Participant
Stewart Brokers	Listening Session
The CarePlace Frank Smith, *Executive Director*	Summit Participant
The Church at Chapel Hill	Listening Session
WellStar – Cancer Screening and Prevention Barbara Foster, *CRC Screening Navigator*	Key Informant
WellStar Cobb Hospital Heath King, *VP Finance and Hospital CFO* Donnie Newsom, *WellStar Cobb Authority Board Chairman* Amy Woodell, *Evidence-Based Coordinator*	Summit Participant Key Informant

Collaborator	Areas of Service
WellStar Congregational Health Network Cindy Newman, *Congregational Nurse*	Key Informant Summit Participant
WellStar Health System Ryan Breshears, *Chief Behavioral Health Officer* Kristin Caudell, *Director, Community Education & Outreach* Darcal Dixon, *Diversity & Inclusion Consultant* Ebenezer Erzuah, *Executive Director - Reimbursement* Missy Laura, *Gutelius Team Lead Population Health* Tyeisha Miller, *Laboratory Manager* Cecelia Patellis AVP, *Community Education & Outreach* Kara Segal, *SFA* Kamela Sooknanan, *AVP - Population Management* Shara Wesley, *Director, Community Benefit* Aisha Williams, *Director -Diabetes Services*	Listening Session and/or Summit Participant
WellStar Health System Kennestone Regional Hospital Board	Listening Session
WellStar Kennestone Community Clinic Jennifer Headrick, M.D.	Key Informant
WellStar Medical Group Carl Goolsby Jr., *Physician*	Summit Participant
WellStar Paulding Raymond Phillips, *Vice Chairman* John Kueven, *Hospital President*	Summit Participant
Zion Baptist Church Eric Beckham, *Senior Pastor*	Summit Participant

WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill Hospitals

Community Health Summit

The following is a summary of the Health Summit held for WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals on December 6, 2018, at the WellStar Development Center in Vinings, GA. The Health Summit was facilitated by GHPC in partnership with WellStar Health System and lasted approximately three hours. The 25 attendees included employees of WellStar Health System and community stakeholders. Community stakeholders represented organizations serving residents in communities included in the primary service area of WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. The organizations that participated in the Health Summit included:

- Austell Community Task Force
- Bethesda Community Clinic
- Cherokee County Chamber of Commerce
- Cobb & Douglas Community Services Board
- Cobb & Douglas Public Health
- Cobb Chamber of Commerce
- Cobb County Fire and Emergency Services
- Cobb Moms Helping Cobb
- Cobb Senior Services
- Connecting Generations
- Douglas County Chamber of Commerce
- Good Samaritan Health Center
- Metro Atlanta Ambulance Service
- Mopdog
- Morehouse School of Medicine
- MUST Ministries
- Paulding Quick Bail
- Professional Mojo Marketing
- Puckett EMS
- Social Security Administration
- The CarePlace
- WellStar Cobb Senior Services
- WellStar Health System
- Zion Baptist Church

GHPC presented findings of the CHNA generated from secondary data analysis, key informant interviews, focus groups, and listening sessions. Health Summit participants were asked to discuss community health needs and were encouraged to add any needs that may have been absent from the assessment's data collection thus far. Participants were then asked to identify the top five health needs that they believed, when collaboratively addressed, will make the greatest difference in care access, care quality, and costs to improve the community health, especially in vulnerable populations. The needs identified by individual groups were consolidated into mutually exclusive health priorities and voted upon to surface community health priorities.

Group Recommendations and Problem Identification

During the Health Summit, attendees prioritized five community health needs of residents within the area served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. The following is a summary of the input attendees offered when asked about contributing factors, potential solutions and community resources to address the health priorities.

Access to Care

Health Summit attendees discussed the limited access that residents have to appropriate care when and where they need it. As the top priority in the service area, attendees discussed the need for transportation, preventive care, insurance coverage options and providers (primary, dental, behavioral healthcare and specialty providers, including diagnostic labs and chronic disease management).

Contributing Factors:

- There are not enough safety-net providers in the area, leaving underinsured and uninsured residents with limited options for medical and dental care. Additionally, specialty care is not available for uninsured residents.
- Provider rates for behavioral health and dental care are lowest in more rural counties in the area.
- Many physicians in the area do not accept Medicaid or Marketplace insurances. Residents may have to travel outside of their area to a provider that will accept the type of insurance they have.
- Some residents may not be able to navigate the health resources in their community or do not possess technological skills/devices needed to navigate effectively.
- Medicaid has not been expanded in the state, which limits access to affordable insurance coverage.
- Cost of uninsured care can be unaffordable for residents earning a low income, including healthcare, behavioral healthcare, dental care and prescription medications.
- The rural nature of many communities requires transportation to get to and from destinations. Public transit is not readily available and disconnected from county to county in this area. Many residents cannot afford private transportation.
- Health services are not always offered in culturally and linguistically relevant ways.
- Many undocumented residents do not have the proper identification to secure healthcare.
- Residents are not always aware of the services that are available in their communities.

Recommendations:

- WellStar could advocate for improved insurance options and affordability of health services for vulnerable patient populations, including funding for clinics (grants, county or municipal funds) and Medicaid expansion.
- Support mobile healthcare screening in communities.
- Increase the availability of after-hours care offered by providers, including after hours (nights and weekends) and walk-in appointments.
- WellStar could partner with Bethesda clinic by offering uninsured patients access to specialty care, with some physicians, nurses, CMAs, etc., serving on-site monthly.
- Negotiate/partner with insurance companies to offer affordable transportation to and from medical appointments.
- Health providers (hospitals and public health) could establish/propose transportation routes that are necessary to public transportation providers based on patient data.
- Increase the communications and dissemination of information that is culturally and linguistically relevant to all populations about available services.
- Health providers could advertise on public buses (1) what is offered at public health and WellStar facilities and (2) what bus lines will take you to those locations.
- Georgia's policy that governs malpractice for free charity care needs to reflect the times. Presently if charity clinics charge any fees, they lose the free sovereign immunity. If charity clinics charge nothing, they do not survive.
- Provide funding for doctors to see 10 percent underinsured and uninsured people in their practices.
- Establish comprehensive care clinics to address specific chronic diseases and provide education about availability.
- Offer dental, medical and psychological examinations at a homeless shelter.
- Telemedicine options could address transportation/access barriers and could (1) address disparity and (2) foster care continuity.

Chronic Disease

Health Summit attendees discussed the need to address chronic diseases in the community. Concerns among summit attendees included the need for healthy food options, physical activity opportunities, awareness and educational opportunities related to healthy nutrition and physical activity for residents. Summit attendees also felt that obesity, heart disease and diabetes rates are high.

Contributing Factors:

- There are high rates of obesity, heart disease and diabetes among residents, in part due to unhealthy lifestyles resulting from limited healthy options and poor health choices.
- Fast food and unhealthy food choices are more readily available than healthy options in this area. As a result, residents are making unhealthy food choices because of time constraints (due to commuting) and convenience of options such as fast food.
- Physical activity is not always available, affordable or a priority for residents.

Recommendations:

- WellStar could ensure more stringent tobacco-free ordinances on their campuses and advocate for county and municipal policies as well.
- Advocate for low-cost grocery stores and farmers' markets in food deserts.
- Providers should offer more preventive care and education through partnerships with community organizations and congregations.

Racial and Ethnic Disparities

Health Summit attendees discussed the racial and ethnic disparities that exist in the communities they serve.

Contributing Factors:

- There are disparities in education, employment, wages, etc., that influence poor health for Black and Latino communities.
- Stress levels are high among residents who experience racism regularly, which contributes to poor health outcomes.
- Undocumented residents do not have access to healthcare, transportation or adequate educations.
- There are cultural barriers to Black residents seeking medical and behavioral healthcare.
- There are limited health services that are culturally and linguistically relevant in the service area.

Recommendations:

- WellStar can collaborate with church congregations to increase awareness and participation in medical and behavioral health services.

Behavioral Health And Substance Abuse

Health Summit attendees prioritized behavioral health and substance abuse as one of the most pressing issues in their communities. Attendees noted that addressing behavioral health and substance abuse needs in their communities will require collaboration among organizations. Their concerns included stigma, limited providers (detoxification, inpatient, outpatient, co-occurrence, etc.), a lack of culturally and linguistically sensitive treatment options and limited resources for uninsured residents.

Contributing Factors:

- The lack of behavioral health providers limits the access residents have, both insured and uninsured, to appropriate care.
- The stigma associated with behavioral health diagnosis and treatment may pose a barrier to residents seeking care.
- There are very few behavioral health providers that offer culturally and linguistically sensitive treatment options for Latino, Black and Asian residents.
- Many residents are becoming addicted to prescription drugs and then moving to cheaper, more available options, such as heroin.
- Heroin overdose rates are high and rising in this area.
- Substance abuse treatment options are limited and unaffordable for uninsured residents.
- There are not enough detoxification, inpatient or outpatient treatment options available in the region to meet the need.
- Treatment options for patients with co-occurring behavioral health and substance abuse diagnoses are limited.
- Currently, a 72-hour hold for a mental health crisis can only be issued in person by a doctor or mental health professional. An attempt to change the state law was defeated in the last state legislative session.

Recommendations:

- WellStar can advocate for a change in the law allowing EMS and police officers to hold mental health patients for 72 hours if they are a danger to themselves or others.
- It is important to find a way to increase recruitment and retention of mental health providers to increase access to mental health services.
- WellStar could increase the number of mental health providers they hire to address community needs.
- WellStar could increase the number of community-wide education programs that they offer.
- Increase the services available for adults and children in crisis situations who need hospitalization to decrease the use of local ERs for behavioral health needs.
- WellStar could partner with other organizations (e.g., CSB) to address and support behavioral health crises among residents that they serve.

Listening Sessions

WellStar Cobb Regional Health Board

(September 2018)

Counties represented: Cobb County

1. What impacts the quality of life in your area?

- Opioid issues countywide
- Too much fast food
- Food deserts – lack of access to more affordable eating
- Need for more education as to access to healthcare
- Availability of child care
- Affordability of healthy food choices
- Inadequate/unaffordable housing
- Lack of health insurance
- School dropouts
- Mental health issues
- Lack of culturally appropriate health services

2. In your opinion, over the past three years, has health and quality of life in your area improved, stayed the same or declined?

- Improved – we have the updated and relatively new burn center, total renovation of the Women's Center. Many improvements have been made.
- Declined – opioid crisis has drastically increased the number of field dosages of Naloxone given.

3. In your opinion, what are the most critical health problems in your area?

- Substance abuse (opioid addiction, illegal drug addiction, alcohol abuse)
- Not going to the doctor
- Unsafe sex
- Lack of exercise
- Not getting prenatal care
- Not getting immunizations
- Poor eating habits
- Not going to the dentist

4. What unhealthy behaviors and social determinants of health have the largest impact on health and quality of life?

- People are not getting regular checkups and annual exams. Instead, they are showing up at the ED with acute conditions.
- The first responders will be a great resource for information because many people use 911 to address their health needs once they are in a crisis.
- Many residents lack the knowledge or have the educational attainment to understand how they can manage their chronic disease.
- Many areas (such as in Mableton) are built for cars and not pedestrians. Therefore, streets are not walkable and safe.
- The area is saturated with junk food options and food deserts.
- Many people access care at the Cobb ER, urgent care clinics and community clinics; not their primary care provider.

5. What else will improve the health and quality of life in your area?

- Continue WellStar's participation in Community Health Fairs and providing prevention screenings (such as blood pressure checks).
- Continue events in South Cobb. These wellness events are well received in the community.
- More resources need to be allocated to address the behavioral health needs in the community.
- Access to healthcare outside of a hospital ER.
- There are some nonprofit groups assisting with access to Naloxone as well as low-cost or free distribution through chain pharmacy facilities.
- One of the most positive things is the medical community taking responsibility for NOT prescribing these addictive drugs. People have surgery now and the process of keeping the wound numb for days is amazing and long overdue. Much better than addictive drugs.
- Going into the community to meet with residents and not expect them to come to us.
- Educating the public on the dangers of prescription drug addiction and the sources of help that they can access.

- Small clinics to address minor issues that provide an option to keep from using a hospital ER.
- Better education on healthy choices related to diet and the dangers of smoking and drugs. This needs to start on a childhood level. The fire department is reporting incidents of elder neglect, including self-neglect, to the EMS Division. They send two members of the division to make a house visit and determine if they can access county programs (such as Meals on Wheels) or contact a nonprofit to get the people access to programs that may improve their way of life.

6. Please list the people or groups of people in your area whose health or quality of life may not be as good as others. Why?

- 30168 and 30126 – High crime areas with related drug issues
- Challenges are related to race and language and educational level

7. What organizations are best at taking care of the health needs of vulnerable populations? What makes them effective?

- Use first responders (paramedicine) to help with access issues.
- The extension provides services and a two-year program for people living with substance abuse disorder. They have a dynamic success rate and can really help people get back to living a productive life.
- Cobb County Fire and Emergency Services has enacted two programs to improve the health and safety of the citizens of South Cobb. We have performed a "Safety Blitz" in impoverished areas of the county two times a year for the last four years. This includes educating children on fire safety, teaching "hands only" CPR and distributing fire extinguishers and smoke detectors. The department is also issuing smoke/carbon monoxide detectors to engines to install in houses if they run a 911 call and don't see one in the house. We also worked with a nonprofit to pick a section of the neighborhood and go house to house installing the detectors for free to houses that needed them.
- Public Health – Access by bus for people without transportation, interpreters for people who don't speak English, free vaccinations and follow-up care.

WellStar Douglas Regional Health Board Listening Session

(October 2018)

Counties represented: Cobb, Douglas and Paulding counties

1. What impacts the quality of life in your area?

- Big need for mental health initiatives to educate the community in access and financial assistance if they have no insurance. I have personally witnessed and have friends and family affected with devastating circumstances. Some not ending so well.
- Access to primary care is very limited for uninsured. Rates of uninsured are still extremely high in our county and those on Medicare who have opted out of Part B, but still have Parts A and D, leaves them vulnerable and unable to get or refill prescriptions because they cannot afford to go to a primary care physician so they use the local ED for this purpose.
- Cost of healthcare
- Obesity
- Crime
- Transportation, which is improving, and insurance availability.
- Lack of information and opportunities to engage people in managing their own care and promoting healthier lifestyle options.
- Drug usage in Douglas County has dramatically increased over the past couple of years, which leads to poor health and poor parenting – again leading to a continual population that has health and quality-of-life issues.
- We have a nonprofit clinic that needs financial support to adequately supply the need.
- Lack of parents that care
- Funding
- Political leadership
- Resistance to change
- Misconception that quality healthcare isn't accessible in Douglas – people think they have to go outside the community for better doctors.
- Education
- Quality employment

2. In your opinion, over the past three years, has health and quality of life in your area improved, stayed the same or declined?

- Improved:
  - The opening of the free medical clinic, The CarePlace, has helped to some degree. Their model is based upon access to primary care physicians, internal medical providers and nurse practitioners. Unfortunately, the 4-1 Care network has not been successful in helping this clinic.
  - More sidewalks built and fitness centers opening in the area. I think the buses will help people in need of transportation to doctor or fitness centers, including senior citizen centers. More urgent care options outside of the ER. Mentality seems to be moving in right direction to think progressively about how to best improve our area.
  - Improved cardiac care at WellStar Douglas
  - Providing more places to get care – additions to hospital
  - Better focus on well-being in schools
  - Insurance option changes (Obamacare)
- Stayed the same:
  - The community has a large number of low-income areas and should offer county-sponsored methods for a healthy lifestyle that can reach all income levels (bike trail, walking trails, etc.).
- Declined:
  - More doctors, more capabilities at the hospital
  - Access to health has improved, but we feel that overall quality of life has declined in the county.

3. In your opinion, what are the most critical health problems in your area?

- Chronic disease and access to primary care to treat and manage them:
  - Hypertension
  - Diabetes
  - COPD
- Behavioral health, including suicide – mental health. I see so many with addiction and depression. Could we have educational format start in the schools where children can be educated on things such as how to deal with stress, mental and emotional health and how diet is a HUGE factor. How to deal with dysfunctional family dynamics, etc. Seems like I have seen some schools in U.S. teaching stress-relief techniques such as tapping, meditation and again diet.
- Overweight population
- Lack of healthy food options for school-aged children
- Lack of affordable preventive services for some areas of the county
- Drug abuse
- Among the indigent, musculoskeletal
- Seniors who need healthcare management for medications and chronic disease
- Violent behavior
- Substance abuse (illegal drugs addiction, alcohol abuse, prescription drugs)
- Poor eating habits
- Lack of exercise
- Not going to the doctor
- Smoking/tobacco use

4. What unhealthy behaviors and social determinants of health have the largest impact on health and quality of life?

- Behavioral health needs are limited in the community
- More is needed to support families that are supporting relatives that are challenged with behavioral health needs.
- Suicide is becoming more prevalent in the community.
- Education and support services, which include the parent and the child.
- No reliable recreational hubs in the city for children and their families.
- More programs in schools that include the parents, so learning can be implemented in the home.
- Patients who are discharged with unmanaged chronic disease are not receiving the prescription medication and follow-up care that they need to get better.

5. What else will improve the health and quality of life in your area?

- Transportation is expanding. A new route for those that have been incarcerated or are homeless to directly access resources.
- After-school programs for youth that includes health activities.
- Increase awareness of the need for more primary care providers to volunteer their time. We know that there are patients who are in need, but the need can only be met with more providers willing to volunteer.
- Education starting at the school level. We need very involved focus groups to have real conversations and dedicate time and effort into coming up with a way to start in school and reach out to those out of school as well. Retirees also need help with dealing with that transition, which can be stressful. Maybe have something in community centers and other communication media for seniors.

- Expanding connected health resources to help at-home seniors, low-income families, low-income students to give them some personalized options and information. Outreach programs that not only provide that population with immediate needs, but that also seek to help them have the ability to care for themselves better – more education, better jobs, better housing opportunities, counseling and community partnerships. Also, increase the available clinics in these areas or for this population to redirect the ER usage for minor problems. More health education and food pantries in the school system.
- Help find financing for The CarePlace, so there is no waiting list.
- More outside control of medical university
- More partnerships in the community with city/county/schools/Chamber to help increase the awareness of not only ways to prevent/understand health issues, BUT to also better promote the options and quality of the hospital and WellStar Services (brag a little more). I have heard of situations where WellStar was asked to partner on programs and they did not participate – some of these have been resolved, but others might still have a bad taste in their mouths and then reactively gravitate toward Tanner or others outside of Douglas.
- Outreach, education, partner with groups who work with these demographics
- Continued focus on green spaces, sidewalks, walkable areas/parks, drug screening and education/prevention programs that are marketed widely.
- Access to affordable care for the "sandwiched" residents – those who are employed and do not qualify for low-income help, but cannot afford to see the doctor because of high deductibles and out-of-pocket co-pays. The general cost to see any specialist is prohibitive for the majority of people I know. So, they don't go.
- Medicaid expansion, transportation options, funding for behavioral health
- Proper healthcare. Places to get treatment not at ER
- Better jobs with new companies moving in offering better health insurance, better access to healthcare.
- Funding The CarePlace will help to provide primary care to those patients who currently use the ED as their primary care provider to choose The CarePlace as their provider of choice.

6. What organizations are best at taking care of the health needs of vulnerable populations? What makes them effective?

- Leverage national organizations that may not have a local chapter in the community to help offer those community-based services that are needed.
- WellStar could really serve as a convener of these groups
- There is financial assistance and programs most people are not aware of. These include services for elderly in need of in-home care.
- Hospital's ability for interventional heart caths – I know of several people who had heart attacks who were treated quickly here.
- The CarePlace has helped by providing ongoing care to manage the chronic illnesses of patients with hypertension, diabetes and others without cost.

7. Please list the people or groups of people in your area whose health or quality of life may not be as good as others. Why?

- The northeast quadrant of Douglas County and the sector just north of the railroad tracks on Hwy. 92 have large portions of working poor. They are most likely to use the ED as their primary care provider and do not have health insurance due to the high cost and high deductibles.
- Uninsured
- Homeless
- Underemployed
- Fairburn Road area seems to be a more transient population with lower income. Doesn't seem to be a good or safe option for something other than apartments. Something such as lower-price townhomes. Rental homes are outrageously priced.
- Northside of Douglasville and City of Douglasville residents. The City has five Title I schools, which indicates a high number of poverty-level households. Income level usually has a direct connection to health and quality of life.
- People who need transportation to healthcare providers
- People with mental health issues
- 30134
- Douglas County, especially the City of Douglasville, has a high number of low-income families that may not have the ability to utilize tools such as telehealth, preventive information, etc.
- Also, we have a high number of children on the free lunch program, so access and information on healthier food choices when they are home is a big hurdle in this area.

WellStar Kennestone Regional Health Board Listening Session

(October 2018)

Counties represented: Bartow, Cherokee, Cobb, DeKalb, Douglas, Forsyth, Fulton, Gwinnett, Paulding and Pickens counties

1. What impacts the quality of life in your area?

- Drug usage and lack of funding for behavioral facilities to treat addictive substance abuse, including – underage alcohol use, growing prescription drug/opioid/heroin use.
- Latino residents continue to struggle in securing appropriate healthcare. Hispanic/Latino population: lack of translators at Public Health Department.
- Prompt access to appointments with primary care physicians for non-emergent, acute illnesses.
- Good options for individuals with private insurance, Medicare and Medicaid.
- Cost and accessibility – few options for uninsured.
- Financial means – low-income families access to healthy preventive care
- Homelessness
- Underemployment issues
- Transportation
- Basic medical knowledge
- Missing hourly work to receive healthcare
- Education to parents and underage youth
- The volume of need continues to increase due to retirees moving into the area with chronic illnesses that require monitoring and evaluation; and the area has become a travel destination for surrounding states. Scheduling appointments must be done weeks in advance and acute non-emergent events are not being promptly treated due to lack of access.
- A lack of funding for those who do not have insurance and very little access without proper funding for mental health facilities to assist people when needed.
- Lack of appropriate services; lack of understanding of the needs to culturally diverse populations
- I would believe knowledge of the programs that WellStar offers would improve the quality of life for residents that are not informed.
- Spanish-speaking providers
- Failure to accept all insurance
- Availability of childcare
- Inadequate/unaffordable housing
- School dropouts
- Affordability of healthy food choices

2. In your opinion, over the past three years, has health and quality of life in your area improved, stayed the same or declined?

- Improved:
  - Additional physicians have been added (Level 1 trauma designation at Kennestone, medical specialties, hospitals and clinics), including making access more convenient, though access is still an issue for non-emergent acute events.
- Declined:
  - More people needing services
  - No access to Samaritan Health

3. In your opinion, what are the most critical health problems in your area?

- Costs, access and shortage of clinicians
- Lack of access to professionals
- Underage drinking and the use of prescription pain relievers/illicit drugs
- Access to treatment for acute non-emergent illnesses. Allergies, colds, flu. Critical health problems would include obesity, cardiac disease and diabetes.
- Behavioral Health – Drug use and mental health issues that go undiagnosed or treated.
- The opioid crisis is critical and effecting numerous families in the suburbs.
- Obesity in our population continues to rise, which causes large problems for individual health across the board.
- Management of chronic diseases – diabetes, cardiovascular, obesity; trauma – falls

4. What unhealthy behaviors and social determinants of health have the largest impact on health and quality of life?

- There is a great need for healthcare professionals and education materials to be available in Spanish and English. Cobb County is becoming increasingly more diverse and WellStar does not appear to be prepared to help these residents.
- East Cobb is often ignored, but many of those residents are not accessing care like they should.
- Youth and their dependence on electronic devices could have long-term cognitive effects on their development.
- Substance abuse and addiction (prescription drugs, illegal drugs, alcohol)
- Lack of exercise
- Not going to the doctor
- Poor eating habits
- Unsafe sex
- Drunk driving
- Smoking/tobacco use
- Suicide

5. What else will improve the health and quality of life in your area?

- By 2020, one in four residents in Cobb County will be Latino. WellStar should offer more support for this growing population
- Long-term substance abuse treatment and services should be more readily available for residents.
- Expand paramedicine and telemedicine offerings for those residents that could benefit from these types of services.
- WellStar can do telemedicine demonstrations at their community events so people understand how it works.
- WellStar should continue the services they offer in the community.
- Less government regulations
- Make patient access to physician consult via telemedicine and conduct in-home health visits for routine checkup/annual evaluations on patients diagnosed with chronic diseases being treated with pharmaceutical therapies.
- There needs to be funding available for treatment centers and mental health facilities.
- Improve access by fostering better collaborations between government entities, healthcare systems and providers and nonprofit groups so that we don't have so many residents "falling through the cracks" because of lack of care.
- Education and more facilities to aid in curing the problems I mentioned above. The jails/prisons are full of people that have behavioral health issues, drug dependencies and are not receiving treatment that can correct these problems.
- Continued community awareness and involvement
- Routine follow-up/pharmaceutical management for chronic disease; environmental scan of living conditions; case manage seniors with mobility issues/chronic disease.
- Incentives for people to get annual physicals, but there must be a plan of treatment when someone is found to have some ailments. I would like to see healthcare systems that at some point reach their peak and then begin spending money on healthcare for those who cannot afford it. I know millions go to fund healthcare for indigent people, but there are way too many mental health issues that are going unchecked that lead to alcohol/drug use, suicide and violent behavior.
- Create convenient access for patients to primary care, in-office visit or in-home visit. Health Parks have helped by creating more access to PCP/outpatient visits, but you still have to schedule appointments weeks/months in advance. Create a single bill for treatment when patients are treated for an event in the hospital, even when seeing multiple specialty physicians employed by WellStar Health System. Patients are receiving up to 10 bills consisting of a hospital bill and one bill for every different physician or specialty that interacts in their care,
- Community forums with all coalitions to brainstorm and develop strategies
- Healthier lunches for schoolchildren
- Proactively addressing the growing population of people with behavioral health concerns in Cobb County with educational outreach about programs readily available to residents/workers in the community. Prescription drug/opioid addiction – tighten controls when these can be prescribed and for how long. State needs to license, inspect and monitor opioid addiction rehabilitation centers.

6. What organizations are best at taking care of the health needs of vulnerable populations? What makes them effective?

- Ser Familia
- Community Health Clinics
- CCAPSA
- WellStar
- The Center for Family Resources
- MUST Ministries
- VIP Physician groups that have opened up over the past five years, granting on-demand access to individuals with unpredictable schedules, I feel it is a benefit to those with acute/chronic illnesses that require ongoing pharmaceutical therapy or occasional lab work.
- Children's Healthcare does a great job educating parents and children about child-specific accident/injury prevention for kids through Safe Kids at athletic events, in schools and community events. WellStar does a good job through Safe Kids.

7. Please list the people or groups of people in your area whose health or quality of life may not be as good as others. Why?

- Residents with low socioeconomic status and in poverty
- Families, particularly single woman with children, living in extended-stay hotels long term. There is a major disparity in care when looking at this group.
- Healthy food access in areas of Acworth (30102 and 30120).
- Underage drinking in high schools
- Use of prescription pain drugs and illicit drugs
- Residents with lower education, lower incomes and an unwillingness or lack of funding for medical care.
- South Cobb, near Osborne High School and various other blighted areas. These areas also seem to have a larger number of children that grow up without proper parenting.
- Latinos through WellStar's coverage area continue to struggle in securing appropriate healthcare. There are barely any culturally and linguistically appropriate mental healthcare and families have difficulty when trying to secure medical care that takes into account their language and culture.

WellStar Paulding Regional Health Board Listening Session

(October 2018)

Counties represented: Cobb, Douglas, Meriwether, Paulding and Troup counties

1. What impacts the quality of life in your area?

- Our area continues to combat opioid and meth abuse.
- Unhealthy personal choices (diet, drugs, etc.), still some tobacco use, lack of exercise, poor eating habits
- Obesity
- Diabetes
- Lack of affordable insurance
- Access to primary/preventive care has become worse; eight months to get an appointment if you don't go regularly.
- No public transportation. If someone doesn't have a car or a ride, how can he/she get to medical facilities?
- Most people want quick convenient food (i.e., fried full of fat and starch, plus sugar-laden desserts), which comprises the major diet of most people.
- Availability of childcare
- Affordability of healthy choices
- Mental health issues
- Domestic violence
- School dropouts
- Inadequate and unaffordable housing
- Unhealthy, unsafe home conditions

2. In your opinion, over the past three years, has health and quality of life in your area improved, stayed the same or declined?

- Improved:
  - The economy has improved a lot in the past three years in our area, so if people choose healthier options, they can better afford them.
  - Better/more convenient facility access
- Stayed the same:
  - Opioid abuse, heroin and the elections have not improved.
  - Access to primary care physicians has become worse. Eight months to get an appointment if you don't go regularly.

3. In your opinion, what are the most critical health problems in your area?

- Obesity and resulting ailments
- Drug dependence/addiction
- Sexually transmitted diseases
- Diabetes, heart problems, other issues related to obesity and poor health habits
- Cancer, some of which is related to smoking, another poor health habit

4. What unhealthy behaviors and social determinants of health have the largest impact on health and quality of life?

- Living an unhealthy lifestyle and being sedentary
- People do not like to leave Paulding County to seek services. This includes healthcare needs.
- If healthcare is not easily accessible, people may not go at all to get the specialty care that they need
- There are limited behavioral health services to support the community
- Poor eating habits
- Substance abuse and addiction (alcohol, illegal drugs, prescriptions)
- Smoking/tobacco use
- Lack of exercise
- Violent behavior

5. What else will improve the health and quality of life in your area?

- WellStar really needs to invest in a dietitian who provides nutrition counseling
- WellStar could support senior communities where people are living near each other
- The community is growing significantly and WellStar Paulding Hospital is an anchor in the community.
- Helping children understand early how to be healthy
- Working with the faith community and using congregation leaders to share where resources can be accessed.
- Improve access to primary care (more doctors, extenders, more AI support)
- Reduce access to opioids, find alternatives
- Insurance reform by state/federal government
- Home-based education
- Bad parents are creating bad parents

- Would health education in schools help? I do think the public service announcements on TV about the dangers of smoking are good.
- Trying to improve public transport issues is important and is complex and potentially very expensive.
- Nagging or scare approaches will not change a person. Pills are so easy to acquire over the counter, which most people prescribe for themselves after watching TV. Education and positive examples are a good start.
- Continue with the work related to opioid use – seeking to further involve and educate the community. Use a similar program to better educate the community on proper diet (even where it differs greatly from the federally supported diet structure).
- Recruit more PCPs to the area
- Personal contact with the long health view in perspective for our citizens. People like me also pray for people where we contact and fellowship. Spiritual health is vital to each person's lifestyle.
- Let's look at what other states, such as CA or and CO, have done to encourage healthier eating and exercise habits.
- Stricter rules on getting disability
- Make it possible for a sick or recently discharged patient to see a doctor or extender within a reasonable timeframe. Review/revise ER policies related to pain medication, drug seekers, etc. Stress dangers of obesity/diabetes in primary care and ERs.
- Add more taxes to tobacco products and alcohol and use the proceeds to fund health initiatives.
- Recess and gym in schools mandatory through middle school
- Partner with schools and with local government to brainstorm and come up with best ideas for the future.

6. What organizations are best at taking care of the health needs of vulnerable populations? What makes them effective?

- Many children participate in youth sports and families use the Silver Comet Trail for physical activity.
- WellStar Paulding Hospital can offer more health education and chronic disease management classes for community members.
- Paulding County will be investing in an aviation school and training program. This will bring employment opportunities for members of the community.
- CareLink Community Clinic will be opened soon and will serve as a great resource for those who are not insured
- Some of the fitness programs that have gained mainstream attention, such as OrangeTheory and CrossFit, have helped. CrossFit recently has been going a step further to address the deficit diets and education.
- Affordable screenings for cancer, prenatal, etc.
- The work that the ACO has done with Medicare patients to reduce hospitalizations is a good example of improving people's lives and reducing costs.
- Nurses following up with discharged patients increases the likelihood that patients are compliant with medications and reduces readmissions.

7. Please list the people or groups of people in your area whose health or quality of life may not be as good as others. Why?

- About 20% of the population is uninsured. Another 20% is insured, but struggle with deductible and co-payment.
- Unemployed
- Those with addictions, including alcohol abuse and tobacco use
- Housing projects in Dallas, 30132
- Diet for all the folks we know needs to improve. We realized that most people eat unhealthy fast food leading to bad heart health and diabetes. We use "Trim Healthy Mama" as our source of good nutrition and healthy foods. We exercise at the "Y" three times each week. I would suggest looking into both the diet approach and exercise I listed.
- Lower income

Key Informant Summary

(August 2018 – November 2018)

Georgia Health Policy Center (GHPC) conducted interviews with community leaders. Leaders asked to participate in the interview process encompassed a wide variety of professional backgrounds, including (1) public health expertise, (2) professionals with access to community health–related data, and (3) representatives of under-resourced populations. The interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to the study.

Methodology

The following qualitative data were gathered during individual interviews with 15 stakeholders in communities served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. Each interview was conducted by GHPC staff and lasted approximately 45 minutes. All respondents were asked the same set of questions developed by GHPC. The purpose of these interviews was for stakeholders to identify health issues and concerns affecting residents in the communities served by the hospitals, as well as ways to address cited concerns.

There was a diverse representation of community-based organizations and agencies among the 15 stakeholders interviewed, including:

- Cherokee County Chamber of Commerce
- Gwinnett, Newton and Rockdale County Health Departments
- WellStar Congregational Health Network
- WellStar – Cancer Screening and Prevention
- WellStar Cobb Senior Services
- Cobb & Douglas Community Services Board
- A.L. Burrus Institute for Public Service & Research
- WellStar East Paulding Primary Care Group
- WellStar Kennestone Community Clinic
- Good Samaritan Health Center
- Austell Community Task Force
- Cobb & Douglas Public Health
- MUST Ministries

When asked what has improved, declined, or remained unchanged in the past three years, stakeholders said the following:

Improved

- Health has improved for those with access to increased employment opportunities
- New workout facilities
- Opened new and expanded healthcare facilities in Cherokee, Paulding and Pickens counties
- More people are insured
- Use of the 2016 CHNA and CHIP to drive decisions
- Addressing mental health needs in Fulton County schools

Stayed the same

- There has been no improvement over time in resources or outcomes for under-/uninsured
- Limited access for uninsured
- Not addressing the Social Determinants of Health in Fulton County
- No improvements in chronic diseases (hypertension, CVD stroke, diabetes and STDs)

Declined

- Those remaining in poverty, health has declined
- There is a lack of clinics and FQHCs
- Premiums and medications are unaffordable
- Residents are uninsured and not seeking care
- Racial and ethnic disparities have become much worse (Rockdale and Gwinnett counties)

Major Health Challenges:

- Common health issues:
  - Obesity
  - Cardiovascular diseases
  - Diabetes (type I and II)
  - Hypertension
  - Stroke
  - Kidney disease
  - Cancer (lung, colon, gastric, breast)
  - Infectious disease (HIV, syphilis, gonorrhea, chlamydia, Hepatitis C
  - Respiratory issues among homeless populations (COPD, asthma)
  - Infant mortality
- Mental health:
  - High prevalence of untreated/ undiagnosed mental issues
  - Self-harm/suicide
  - Substance abuse (opioid/heroin, alcohol, methamphetamines)
- Poor dental health among uninsured
- Disparities among people of color

Context and Drivers:

- Access to care:
  - Limited access to affordable uninsured care. Physicians have to refer patients to care outside of their communities. Uninsured residents diagnosed with cancer or kidney disease do not have access to the ongoing treatment that they require, due to unaffordable cost, which often leads to frequent emergency room visits and higher medical bills over time.
  - It can take more than a month to secure an appointment, proper medication and care coordination for uninsured and homeless people.
  - There are limited specialty providers in some communities (e.g., neurologists and OB/Gyn) and it can be difficult to recruit to more rural or under-resourced areas. Uninsured specialty care is unavailable/unaffordable for residents in the service area.
  - Uninsured rates are high among under-resourced residents.
  - Many primary care providers do not accept Medicaid or Marketplace insurances.
  - Co-pays and deductibles can be unaffordable for residents.
  - The health services that are available in under-resourced communities can be perceived as sparse and low quality.
  - The healthcare system is difficult to navigate due to limited care coordination for uninsured
- Behavioral health can be difficult to secure in a timely fashion due to:
  - The lack of local behavioral health providers (therapy, medication, inpatient)
  - Uninsured care is not affordable
  - Limited uninsured care (inpatient, outpatient, psychiatry) and general lack of treatment options for co-occurrence (substance use and behavioral health)
  - Lack of awareness about what resources are available
  - There is a stigma associated with seeking and securing behavioral health; this includes cultural stigma among African-American residents.
- Substance abuse:
  - Opioid use is increasing among middle-aged and younger White men and causing high rates of death in Cobb, Douglas and Gwinnett counties – not as prevalent in Paulding, Cherokee, Pickens and Bartow counties.
  - Higher rates of alcohol and methamphetamine use among homeless and incarcerated/previously incarcerated populations.
- Low socioeconomic status related to low-wage employment, poor educational attainment, poor job skills and training. Many employment opportunities have moved out of several communities.
- Low health literacy related to low educational attainment and a lack of literacy influence people's ability to fill out forms and understand outreach education.
  - Education about STI avoidance and healthy practices is not offered to youth in a public way.
  - Racial and ethnic disparities
  - Undocumented residents do not have access to insurance. Barriers related to language and low literacy levels make effective communication difficult.
  - Many residents resist seeking care due to a lack of culturally and linguistically relevant services.
- Housing issues:
  - Healthy housing is becoming less affordable and residents have to make choices between healthy options (food, preventive care, medications, etc.) and the cost of their housing, because they cannot afford everything.
  - Homelessness is increasing and the population of homeless people is aging. Homelessness has a negative impact on health and older homeless people tend to have undiagnosed and unmanaged chronic health issues (COPD and diabetes).
  - When patients are released from the ER, they have nowhere to place them, due to a lack of homeless shelters.
- Healthy food:
  - In under-resourced communities, there are a limited number of grocery stores, coupled with high rates of fast-food restaurants. Austell Road, for example, has limited healthy options available.
  - There is limited promotion of healthy foods in outreach efforts (e.g., cooking classes, etc.).
  - Cultural and traditional preferences can be unhealthy.
  - Healthy foods are often unaffordable and do not last long enough for under-resourced households and many families have to purchase canned and frozen foods with preservatives.
  - Homeless shelters and food banks do not always offer healthy options for diabetics, etc.
  - Many residents do not have time to shop for and prepare healthy foods due to work schedules and traffic.
- The environment does not promote physical activity (e.g., no sidewalks/broken sidewalks, poor lighting, lack of safety).

- Transportation:
  - There is limited access to public transportation in many counties, including Douglas, Newton and Paulding counties. The public transportation that does exist can be unreliable (e.g., often behind schedule) and disconnected from county to county.
  - Many under-resourced residents do not have access to private transportation and may not be able to afford public transportation (e.g., homeless, seniors, etc.).

Recommendations:

- Begin to identify and refer patients with needs related to social determinants of health.
- Advocate for Medicaid expansion and more medical schools to train professionals.
- Provide behavioral health crisis beds, detoxification services, counseling services and psychiatric care to under-resourced residents, including in Cobb County.
- Increase incentives to work in mental health field.
- Implement national best practices to address local health needs.
- Increase culturally and linguistically relevant outreach and education about the need to secure a medical home, manage chronic disease, secure preventive care, the value of treatment, prescription assistance programs, etc.
- Support local farmers' markets to offer fresh produce in communities where it is not readily available. Ensure that diabetics have access to nutritious and healthy options.
- Offer transportation to and from medical services weekly or monthly, specifically in under-resourced communities.
- Increase information that is available about the need for healthy physical activity and the resources that are available in local communities.
- Increase education and training of providers related to cultural, racial and ethnic sensitivity. Talk with community leaders and representatives of various populations to better understand what the barriers and issues are for communities in seeking and securing effective treatment options.
- Work directly with non-health-related organizations and churches to offer up-to-date information and referral directories.
- Offer comprehensive adolescent health education in schools.
- Increase early prevention and intervention methods (e.g., screenings and referral, education, etc.).
- Look for public-private partnership opportunities to address needs.
- Address health need in policy, systems and environments where they occur.
- Divert people from the penal system when they have behavioral health issues.
- Interface more regularly with public health departments.
- Increase the electronic resources available in communities.
- Focus on addressing the root causes of these health issues.
- Promote physical activity and movement in recreation centers and other locations in the community during winter months.
- Expand the Mental Health First Aid Program into Cobb County, including churches.

Resident Focus Group Summaries

(October 2018)

Purpose

This assessment engaged community residents to develop a deeper understanding of the health needs of residents they serve as well as the existing opinions and perspectives related to the health status and health needs of the populations in communities served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals.

Methodology

GHPC recruited and conducted two focus groups among residents living in the communities served by WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill hospitals. GHPC designed facilitation guides for focus group discussions. Residents were recruited using a third-party recruiting firm. Recruitment strategies focused on residents who had characteristics representative of the broader communities in the service area, specifically communities that experience disparities and low socioeconomic status. Focus groups lasted approximately 1.5 hours, during which time trained facilitators led six to 12 participants through a discussion about the health of their communities, health needs, resources available to meet health needs and recommendations to address community health needs. All participants were offered appropriate compensation ($50) for their time and a light meal. The following focus groups were conducted by GHPC during October 2018:

- WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill Hospitals Service Area Residents – Marietta, GA (October 2, 2018)
- Residents from Bartow, Carroll, Cobb, Cherokee, Douglas and Paulding counties – Austell, GA (October 17, 2018)

Focus groups were recorded and transcribed with the informed consent of all participants. GHPC analyzed and summarized data from the focus groups to determine similarities and differences across populations related to the collective experience of healthcare, health needs, and recommendations, which are summarized in this section.

Target Population:
WellStar Cobb, WellStar Douglas, WellStar Kennestone, WellStar Paulding and WellStar Windy Hill Hospitals Service Area Residents

Location:
Sibley Public Library
1539 S. Cobb Dr
Marietta, GA 30060

Number of Participants:
11

Major Health Challenges:

- Obesity (adult and childhood)
- Cardiovascular disease (hypertension and high cholesterol)
- Stroke
- Diabetes
- Kidney disease
- Cancer
- Behavioral health (depression, anxiety, stress)
- Asthma
- STIs (AIDS)
- Substance abuse (marijuana, crack/cocaine, opioids, heroin)
- Smoking/vaping

Context and Drivers:

- Access to care:
  - Limited provider options and hospital and provider closing (hospital in South Cobb County)
  - Providers do not always accept Medicaid or Marketplace insurances.
  - The cost of underinsured/uninsured medical and dental services and medications are often unaffordable for under-resourced residents. Co-pays and deductibles can be unaffordable for residents with low-cost insurance plans.
  - Lengthy wait times for appointments with primary and specialty care physicians.
  - Preventive care is not always available or affordable.
  - Residents do not always trust providers and providers are not taking the time to build trust with patients.
- Residents are disconnected from family, which can contribute to unhealthy behaviors and limited awareness about health risks associated with family history.
- Residents are not always making healthy choices (e.g., preventive screenings, diet, physical activity, etc.).
  - Commute times leave little time for grocery shopping, cooking and physical activity.
  - Children do not have access to healthy options (e.g., recreation, nutrition, etc.).
  - Fast-food options are readily available.
  - Residents are not always aware about what the healthy options are.
- There is limited investment in healthy infrastructure (sidewalks, parks, street lighting, etc.).
  - Residents must rely on cars to get from one place to another due to the distance between destinations and the lack of sidewalks and trails.
- Behavioral health:
  - Residents avoid seeking care due to stigma associated with behavioral health.
- Air quality is poor, which influences respiratory disease.
- Healthy choices are not always promoted (e.g., social media, etc.).

Recommendations:

- Offer incentives to seek preventive care (e.g., reduction in insurance premiums and monetary rewards).
- Employers could offer healthy options at work (e.g., gym facilities, healthy meals and snacks).

Target Population:
Residents from Bartow, Carroll, Cobb, Cherokee, Douglas and Paulding counties

Location:
South Cobb Recreation Center
875 Riverside Parkway
Austell, GA 30168

Number of Participants:
11

Major Health Challenges:

- Obesity (adult and childhood)
- Behavioral health (depression, anxiety, stress)
- Poor eyesight and attention span (related to screen time)
- Substance abuse (marijuana, crack/cocaine, opioids, heroin, alcohol, methamphetamines)
- Diabetes
- Cardiovascular disease (hypertension, high cholesterol)
- Smoking/vaping

Context and Drivers:

- Access to care:
  - Residents are not always able to afford health insurance.
  - Insurance status influences the quality of care patients receive. For example, patients who are uninsured or have Medicaid or Marketplace insurances perceive that they are treated poorer than those with other types of insurance.
  - Not all providers accept cash, Medicaid or Marketplace insurances.
  - Uninsured care (medical, behavioral and dental) is unaffordable for many residents.
  - High co-pays and deductibles are unaffordable for residents with low-cost insurances.
  - Physicians are not offering care that is patient-centered.
  - Perceived to be influenced by race and gender, African-American women are treated differently than other patients.
- Residents are not always making healthy choices (e.g., physical activity, diet, etc.).
  - Many children and adults are engaging in technology (TV, phones, computers, etc.) instead of being physically active.
  - Residents perceive there is a lack of safety and high crime rates.
  - Residents do not always have time to grocery shop, prepare meals or participate in physical activity due to work, commute times and limited financial resources.
  - There is a high rate of fast food in under-resourced areas, coupled with low rates of healthy options (grocery stores, farmers' markets, etc.).
  - Parents may not have time to supervise youth appropriately due to single-parent home or time spent working multiple jobs.
  - Youth are not always getting healthy meals.
  - Healthy options are not always affordable (healthy foods, gym memberships, etc.) and may not last long enough or feed enough people to be economical for families.
  - Residents are not always aware of how to prepare healthy options in healthy ways.
- Behavioral health:
  - Tied to perceptions of safety
  - Parents at times have to choose unhealthy options because they cannot afford healthy options; this causes stress and anxiety.
  - Services are not readily available, particularly in under-resourced communities.
  - Uninsured care is unaffordable to many residents.
- Substance abuse is most visible in under-resourced areas.
  - Prescriptions are not being monitored to ensure patients are not becoming addicted and residents are not educating themselves.
- Crime and safety:
  - Youth are getting into trouble due to limited supervision.
  - Residents do not feel safe to exercise outside.
  - Fear influences mental health
- Some grandparents are raising grandkids, due to parents in the penal system or behavioral health.
- People are disconnected from their communities.
- Housing:
  - Residents have to make choices between paying for housing and healthy options, such as produce, preventive care and medicines.

Recommendations:

- None

Primary Data Collection Tools

Key Informant Questionnaire

(2018–2019)

Before we begin, please remember not to use any names or identifying information about yourself or other people.

Context

In your opinion, over the past three years, has health and quality of life in your county:
(Circle or highlight your selection.)

Improved Stayed the same Declined Don't know

Please explain why you think the health and quality of life in the county has improved, stayed the same, or declined and any factors informing your answer.

- What in your opinion are the district's/county's biggest health issues or challenges that need to be addressed? Gaps? Strengths?
- In your opinion, who are the people or groups of people in your county whose health or quality of life may not be as good as others? Why? Please note any zips/areas where there are health disparities/pockets of poverty.
- What do you think are some of the root causes for these challenges? What are the barriers to improving health and quality of life?
- How important an issue to the district/county is the reduction/elimination of health disparities? What is your perception of current disparities?
- What specific programs and local resources have been used in the past to address health improvement/disparity reduction? (To what extent is healthcare accessible to members of your community? Might cite examples of programs by disease state, life stage, or otherwise)

Community Capacity

- Which community-based organizations are best positioned to help improve the community's health?
- Do you see any emerging community health needs, especially among under-resourced populations, that were not mentioned previously? (Please be as specific as possible.) (How does this impact the health of residents?)

Moving the Needle

- If you could only pick three of these health issues, which are the most important ones to address either now (short term) or later (long term)? What should be the focus of intervention by county/district/community?
- Supportive network to help residents in a one-stop place. How do we address these issues in a comprehensive way using existing resources and stitching together a safety-net for residents most at risk?
- Why did you pick these?
- What interventions do you think will make a difference? Probe for different types of interventions.
- Do you have any other recommendations that you would make as they develop intervention strategies?

Wrap Up

- Is there anything we left out of this survey that we need to know about the most pressing health needs of the community you serve?

Focus Group Discussion Guide

Community Health Needs Assessment

Overview of Purpose of Discussion and Rules of a Focus Group

Facilitator introduces self and thanks those in attendance for participating

Facilitator explains purposes of discussion:
The project is being undertaken by WellStar Health System. They are seeking ways to improve the health of residents in your community. They would like to hear from people who live in these counties. They are particularly interested in your feelings about the health and health needs of the community, how the health-related challenges might be addressed, and what is already in place in your community to help make change happen. More than just determining what the problems are, they want to hear what solutions you all have to address the needs and what you would be willing to support in terms of new initiatives or opportunities.

Explain about focus groups:

- Give-and-take conversation
- I have questions I want to ask, but you will do most of the talking
- There are no right or wrong answers
- You are not expected to be an expert on healthcare, we just want your opinion and your perspective as a member of this community
- You don't have to answer any questions you are uncomfortable answering
- It is important to speak one at a time because we are recording this conversation
- Your names will not be used when the tapes are transcribed, just male or female will appear on any transcript
- I want to give everyone the opportunity to talk, so I may call on some of you who are quiet or ask others to "hold on a minute" while I hear from someone else, so don't take offense
- Please remember that what people say in this group is confidential. I ask that you do not share what you heard from others outside of this group.
- You will be asked to talk about yourself, your family, and your friends today. Please do not use anyone's name in your comments.
- Here is an informed consent form for you to read along with me and then sign if you decide to participate today. It is important for you to know that your participation today is completely voluntary. You can stop your participation now, or at any time. *(Read informed consent, collect signatures)*

Participant Introductions

Please go around the table and introduce yourself and tell us how long you have lived in [this county/community].

I am going to ask you all a series of questions about your own family's health first, and then some questions about what you see happening in your larger community related to health and well-being.

Health Concerns for Your Family

1. What does the term "healthy lifestyle" mean to you?
2. Do you think you and your family have healthy lifestyles? Why or why not? What affects your ability to be healthy? What prevents you from being as healthy as you would like to be?

I want to go a bit deeper in a few areas related to your and your family's health.

3. Let's start with healthy eating. Most of the time, do you and your family eat as healthily as you would like? What prevents you from eating healthily? (Probe for cultural issues, access to healthy food.)
4. What do you think would make you change your eating habits? What could make it easier for you and your family to eat healthier?
5. Now let's talk about physical activity. What kinds of physical activity do you and your family engage in? Do you think you get enough physical activity to be healthy?
6. What keeps you and your family from being as physically active as you would like to be? What would help you and your family get more exercise? What could be done in your community to help you and your family to become more physically active?
7. How about tobacco use? How prevalent is tobacco use among your family and friends? Do you think most people are aware of the risks related to tobacco use? Knowing those risks, why do you think people continue to use tobacco products? What do you think it would take to change people's habits when it comes to tobacco use?
8. Are drug and alcohol abuse a problem in your community? What contributes to this problem? What could be done to address the problem?
9. Another health issue of concern is risky sexual behavior among teens. Do you see this as prevalent in your community? Are there support services to help teens deal with this type of issue? What more could be done?
10. When you think about the health concerns we have discussed – healthy eating, physical activity, tobacco use, drug and alcohol use, and risky sexual behavior – do you know of any resources/programs/services in your community that help with these issues? Are the services that are available adequate to meet the need? Are there different types of services that would be more appropriate or effective?
11. Do you and your family have somewhere or someone that you go to for routine medical care? When you go there, does anyone ever talk to you or provide you with information about the health issues we have been discussing – weight, exercise, healthy eating, tobacco, drug and alcohol use, sexual behavior? Do you think your primary care provider should ask you about these issues? Provide you with information? Help you to change your habits?

Health Concerns in the Community

12. Now let's talk about your community. Please tell me about the strengths/positives in your community.
13. Do you think that most people in your community are healthy? Do you know many people that have chronic diseases such as diabetes, high blood pressure, heart disease?
14. Do you think that there is something about your community that contributes to people having these types of issues?
15. Do you think that people with chronic illnesses have access to the health services they need in order to control their diseases? Why or why not? What services are needed in your community to support those with chronic disease?
16. What do you see as the role of the hospital or health system to address these issues?

Facilitator: Present community-appropriate data summary to participants.

17. What is your reaction to this information? Does it ring true to what you know about your community? Is there anything missing from these data that you believe to be true about your community?
18. What do you think is the best/most effective way to begin to address these issues?
19. Considering the information that I just presented to you, along with your own experience with critical health needs here, which one or two of these health issues should be the priorities for addressing over the next three years?
20. What suggestions do you have for making specific changes in your neighborhood or community? This is another opportunity to make suggestions about needed programs, changes in the community, educational campaigns, etc. that would best meet the needs of this particular community.
21. In communities, people often talk about community leaders. Tthese are organizations or individuals that everyone knows, places/people that you seek out when you need information that is trusted.

    Do you know of these types of organizations or people who are concerned about health issues and serve as leaders in trying to improve health in your community? Who are they? What are they doing? Are their efforts successful? Why or why not?
22. Would these organizations or people be good leaders for addressing other health issues in the community? If not them, then who?
23. What should be done to ensure that children in your community finish their education and can find jobs?

Closing

24. How would you like your community to be different in five years in order to be a healthier place for you and your family to live? If you could make two or three changes that would promote better health, what would they be?

Community Facilities, Assets and Resources

Not an all-inclusive list (December 2018–January 2019)

Health Departments

Bartow County Health Department
100 Zena Drive SE
Cartersville, GA 30121-2482
Phone: 770-382-1920
Fax: 770-387-3999

Paulding County Health Department
451 Jimmy Campbell Parkway
Dallas, GA 30132
Clinic: 770-443-7881
WIC: 770-443-7900
Fax: 770-443-7885

Carroll County Health Department
1004 Newnan Rd., Carrollton, GA 30116
Phone: 770-836-6667
Fax: 770-836-6722

Programs:

- Babies Can't Wait
- Breast and Cervical Cancer
- Children 1st
- Children's Medical Services
- Early Hearing Detection and Intervention (formerly UNHSI)
- Family Planning
- Health Check
- Health Promotion
- HIV / AIDS
- Immunizations and Vaccinations
- Infectious Diseases
- Other Programs and Services
- Pregnancy / Women's Health Medicaid
- Sexually Transmitted Infections
- Tuberculosis (TB) Prevention and Control
- Vital Records
- WIC

Cherokee County Health Department
Canton Office:
1219 Univeter Road
Canton, GA 30115
770-345-7371

Woodstock Office:
7545 North Main Street, Suite 100
Woodstock, GA 30188

Provides some sliding scale community services with tracking and follow-up.

DeKalb County Board of Health
Health Centers:

Clifton Springs
3110 Clifton Springs Road Decatur, GA 30034
404-244-2200

East DeKalb Health Center
2277 S. Stone Mountain-Lithonia Road
Lithonia, GA 30058
770-484-2600

North DeKalb Health Center
3807 Clairmont Rd., NE Chamblee, GA 30341
770-454-1144

Richardson Health Center
445 Winn Way Decatur, GA 30030
404-294-3700

T.O. Vinson Health Center
440 Winn Way Decatur, GA 30030
404-294.3762

dekalbhealth.net

At the DeKalb County Board of Health, we envision safe, healthy communities in which all individuals have access to quality, affordable health services.

We offer many clinical, case management and outreach health services for children, adults and seniors.

Available services:

- Vital Records
- WIC
- Women's Health
- M.O.R.E.
- Babies Can't Wait
- Children's Health
- Childrens Medical Services
- Men's Health
- Dental Health
- Senior's Health
- Teens & Adolescent Youth
- Immunizations
- Refugee Health
- Sexually Transmitted Diseases (STD)
- HIV/AIDS
- Travel Clinic
- Tuberculosis Program

Health Departments (continued)

Fulton County Department of Health and Wellness (FCDHW) Fulton County Public Health 10 Park Pl S.E., 5th Floor Atlanta, GA 30303 404-613-1205	Fulton County Department of Health and Wellness (FCDHW) is the largest testing site in the state of Georgia. Over 700 people each year learn that they have been infected with HIV in our clinic. Our clients are introduced to the HIV Clinic physicians on the same day they may learn their HIV positive status. Enrollment in the HIV Clinic offers an individual a full service outpatient clinic with a TEAM approach to educate and support the patient and families living with HIV.
East Cobb Public Health Center 4958 Lower Roswell Road, Suite 120 Marietta, Georgia 30068 Phone: 678-784-2180 **Acworth Public Health Center** 4489 Acworth Industrial Drive Acworth, Georgia 30101 Phone: 770-974-3330 **Marietta Public Health Center** 1650 County Services Parkway Marietta, Georgia 30008 770-514-2300 **Cobb County Health Center 1650 County** Services Parkway Marietta, GA 30008 770-514-2300 **South Cobb Public Health Center (WIC)** 875 Riverside Parkway, Building 1 Austell, Georgia 30168 Phone: 678-385-136 **Douglas Public Health Center** 6770 Selman Drive Douglasville, Georgia 30134 Phone: 770-949-1970 Fax: 770-942-9469	Cobb & Douglas Public Health, with our partners, promotes and protects the health and safety of the residents of Cobb and Douglas counties. We work to achieve healthy people in healthy communities by: ■ Preventing epidemics and spread of disease ■ Protecting against environmental hazards ■ Preventing injuries ■ Promoting and encouraging healthy behaviors ■ Responding to disasters and assisting in community recovery ■ Assuring the quality and accessibility of health care

Primary Care (FQHCs/Safety-Net Clinics)

The CarePlace 1707 N. Blairs Bridge Rd. Austell, GA 30168 678-945-0700 678-945-0701 Info@thecareplacedc.com	Mission: To be the most loving healthcare facility in our community! Vision: The CarePlace exists to provide free but quality healthcare to the working poor of Douglas County. Our call is to touch the hurting with Jesus' love and compassion.
Good Samaritan Health Center 1015 Donald Lee Hollowell Pkwy. NW Atlanta, GA 30318 Phone: 404-523-6571 Main Fax: 404-523-6574 Medical Fax: 404-523-6575 **Good Samaritan Health Center at Cobb** 1605 Roberta Drive SW Marietta, GA 30008 770-419-3120 www.goodsamcobb.org	For many the access to quality healthcare like regular check-ups and exams, prenatal care, dental visits, health education and counseling all seem, though sometimes burdensome, a necessity to living a well-balanced life. Too often however families must make a choice between the basics of food and shelter or preventive healthcare that could not only change their lives, but many times save them. The Center offers medical, dental, health education, mental health, and social services. Patients pay on a reduced sliding fee scale based on income and household size with the remaining costs provided by donations. At The Good Samaritan Health Center, the entire family receives quality healthcare in an atmosphere of dignity and respect, regardless of race, ethnicity, or religion.

Primary Care (FQHCs/Safety-Net Clinics) (continued)

YourTown Health 202 Croft St Carrollton, GA, 30117-3803 770-834-2255	Our mission is to provide comprehensive preventative, curative, and life-enhancing services in a non-judgmental and compassionate environment. Our doctors, physician assistants, nurse practitioners, and support staff are able to provide you and your family with quality, comprehensive medical care every step of the way. We offer pediatric and adolescent care, family practice and internal medicine, obstetrics and gynecology, dentistry, and pharmacy services. Our Community Medical Centers also provide immunizations, diagnostic testing and laboratory services, school and work physicals, and referrals to qualified specialists.
The Family Health Center At Douglas County Schools 8277 Connally Dr, Douglasville, GA, 30134-3840 770-651-2273 **The Family Health Center at Cobb** 805 Campbell Hill St NW, Marietta, GA, 30060-1144 770-919-0025 **The Family Health Center at Lake Forest** 5920 Sandy Springs Cir, Sandy Springs, GA, 30328-5937 470-254-0001 **The Family Health Center at Kidcare** 910 Dannon Vw SW, Ste 2102 Atlanta, GA, 30331-2156 404-691-6100 **The Family Health Center at West End** 868 York Ave SW, Atlanta, GA, 30310-2750 404-752-1400 **Mobile Medical and Dental Unit** 868 York Ave SW, Atlanta, GA, 30310-2750 404-752-1400	Our Mission The mission of The Family Health Centers of Georgia, Inc. is to provide high quality patient centered healthcare with a commitment to excellence. Services: ■ Adult Medicine/Family Practice ■ Dental ■ Laboratory ■ Pediatrics/Adolescents ■ Pharmacy Vision ■ Women's Health, OB/GYN and Family Planning
Oakhurst Medical Centers Main Office / Stone Mountain Location 5582 Memorial Drive, Stone Mountain, GA 30083 Decatur Location 1760 Candler Road, Decatur, GA 30032 404-286-2215 Northlake location 2295 Parklake Drive, Suite 500, Atlanta, GA 30345 Other Locations 2140 Peachtree Road NW, Suite 232, Atlanta, Georgia 30309 550 Peachtree Street, Atlanta, GA 30303	Oakhurst is a community based, not for profit, primary healthcare center. Since 1980, we have been providing quality, affordable, culturally sensitive and accessible healthcare to the residents of DeKalb County. We also serve Fulton County.
Southside Medical Center 1046 Ridge Avenue, SW, Atlanta, GA 30315 404-688-1350 southsidemedical.net Southside Medical Center has centers throughout metro Atlanta in Norcross, East Point, Riverdale, Hampton and Forest Park.	Offering affordable healthcare and related services including Pediatrics, Adult Medicine, Women's Health, Dentistry, Optometry and Specialty Services Also offered: Southside Behavioral Lifestyle Enrichment Center (SBLEC) serves all men and women, aged 18 and older, who seek to overcome the use of any type of drug or alcohol.

Primary Care (FQHCs/Safety-Net Clinics) (continued)

Mercy Care at City of Refuge
1300 Joseph E. Boone Blvd.
Atlanta, GA 30314
678-843-8790

Mercy Care at Gateway Center
275 Pryor Street SW
Atlanta, GA 30303
678-843-8840

Mercy Care at St. Jude's Recovery Center
160 Pine Street
Atlanta, GA 30308
678-843-8544

As your medical home, Mercy Care offers comprehensive services that meet the majority of primary physical and mental health and wellness needs. Services are planned and delivered by a team that works together for your health. These services include primary medical care for adults and children, primary dental care, vision care, mental and behavioral health assessment and counseling, prescriptions, health screenings, and health education.

GHMS Bartow Family Health Center

Operated by Georgia Highlands Medical Service Inc.

775 West Ave Ste A
Cartersville, GA, 30120-3482
770-887-1668

Mission and Vision
The Mission of Georgia Highlands Medical Services is to provide quality health care and the best patient experience to those we serve.

The Vision of Georgia Highlands Medical Services is to be the provider of choice for family medical services in our area.

Services:

- Family Practice
- Pediatrics
- Women's Health / OB-GYN
- Geriatrics
- Pharmacy
- Support Services
- Family Planning

Behavioral Health/Substance Abuse

Next Step Ministries, Inc.

7709 Turner Road, Woodstock, GA, 30188
770-592-1227

nsm@nextstepministries.net

Next Step Ministries serves families in Cherokee, Cobb and Fulton counties. We provide safe, appropriate and interactive day programs for individuals with unique needs in a Christian environment. Our mission is to improve the quality of life, not only for these individuals, but for their families and others who assist in their care.

Next Step Ministries provides a variety of therapeutic day programs to meet the needs of our moderately to profoundly developmentally delayed population.

Luke's Place

420 McDonough Blvd., Atlanta, Georgia 30315
Phone: 404-635-0088
Fax: 404-635-0088

tlhightower@gmail.com

Bible Based, Christ Centered, Holy Spirit Lead, Mission Bound

Luke's Place Christian Recovery Home is the result of the visions of Dr. C. M. Alexander and Rev. K. L. Alexander. Through Rev. Kenneth Alexander's struggle with addiction, Dr. C. M. Alexander was able to see the issues many men face today. Because of God, a supportive family a supportive job and adequate healthcare insurance, Rev. K. L. Alexander was able to receive the help he needed.

Ridgeview Institute

Smyrna Location:
3995 South Cobb Drive
Smyrna, Georgia 30080

Monroe Location:
709 Breedlove Drive
Monroe, Georgia 30655

844-350-800 for immediate assistance and assessments

Ridgeview Institute, two private hospitals treating people with addiction and mental health problems, has earned a national reputation for care and service. Since 1976, more than 90,000 people have turned to Ridgeview Institute Smyrna during crisis, despair, and in hope. Now Ridgeview Institute Monroe is offering services in eastern Atlanta.

Programs:

- Adult Addiction Program
- Adult Psychiatric Program
- Senior Adult Program
- Recovering Professionals
- Women's Connection
- Young Adult Addiction Program
- Youth Program

Services

- Family Workshop
- Recovery Residences
- Support Groups

Behavioral Health/Substance Abuse (continued)

The Fulton County Department of Behavioral Health & Developmental Disabilities

Fulton County Government Center
141 Pryor Street, Suite 1031
Atlanta, GA 30303
404-613-7013

www.livebetterfulton.org

Mental Health - Our behavioral health centers offer a wide range of services & addictive disease treatment at community-based locations.

Developmental Disabilities - Three regional centers provide clients with life skills training tailored to their particular disability. Mobility training and day habilitation are also provided.

Addictive Diseases - We provide a variety of specialty outpatient treatment services for adults with chronic chemical dependencies. Treatment is also available for individuals who have both mental health and substance abuse ("co-occurring") disorders.

Southside Medical Center

1046 Ridge Avenue, SW, Atlanta, GA 30315
404-688-1350

southsidemedical.net

Southside Medical Center has centers throughout metro Atlanta in Norcross, East Point, Riverdale, Hampton and Forest Park.

Offering affordable healthcare and related services including Pediatrics, Adult Medicine, Women's Health, Dentistry, Optometry and Specialty Services

Also offered:

Southside Behavioral Lifestyle Enrichment Center (SBLEC) serves all men and women, aged 18 and older, who seek to overcome the use of any type of drug or alcohol.

Resource Assistance

Georgia Family Connection Partnership, Inc.

235 Peachtree St., Suite 1600
Atlanta, GA 30303-1422
Phone: 404-527-7394
Fax: 404-527-7443

Our Vision
We envision a Georgia where all children are healthy, primed for school, and succeed when they get there; where families are stable, self-sufficient, and productive; and where communities are vibrant, robust, and thriving.

Our Purpose
Georgia Family Connection connects and convenes key community members committed to improving the well-being of children and families. We connect our partners to the resources they need, coordinate and manage efforts, and empower our communities to craft local solutions based on local decisions.

Youth Programs

YMCA of Metro Atlanta

101 Marietta St NW #1100, Atlanta, GA 3030

www.ymcaatlanta.org/locations

Multiple locations in schools and the community throughout Atlanta

Reflecting its Judeo-Christian heritage, the YMCA of Metro Atlanta is an association of volunteers, members and staff, open to and serving all, with programs and services which build spirit, mind, and body. Financial assistance is available based on need. The YMCA actively seeks to identify and involve those in need.

YMCA Youth Programs:

- Afterschool
- Early Learners
- Teen
- Overnight, Summer and Holiday/School Break Camps
- Youth and Adult Fitness programs and activities

Youth Programs (continued)

View Point Health Administrative Offices

175 Gwinnett Drive, Ste. 260,
Lawrenceville, GA 30046
Executive Office Main: 678-209-2370

Adult Crisis Stabilization Unit
Lawrenceville, GA 30045
Main: 678-209-2460
Fax: 770-682-9650

Adolescent Crisis Stabilization Unit
2591 Candler Road, Decatur, GA 30032
Main: 678-209-2710
Fax: 678-212-6304

Other locations:
www.myviewpointhealth.org/site-finder.da

Vision:
Building healthy lives and healthy families through high quality comprehensive care.

Mission:
To promote overall health and improve quality of life by ensuring the delivery of effective behavioral and physical health care that meets the needs of communities we serve.

Healthy Food Resources

Food Well Alliance

970 Jefferson St. NW, Atlanta, GA 30318
404-419-1740

info@foodwellalliance.org

Food Well Alliance envisions a livable, resilient Metro Atlanta growing, sharing and eating healthy, local food.

Food Well Alliance operates in ways that are equitable, collaborative and transparent to:

- Identify, invest in and promote innovative ways to strengthen the local food economy and how it is valued
- Strengthen local urban growers and markets to increase production of sustainably grown, local food
- Increase production of and access to local compost
- Connect people ideas and capital to strengthen the local food system

Wholesome Wave Georgia

404-551-5996

info@wholesomewavegeorgia.org

Mission:
We strive to increase access to fresh, healthy, locally-grown food for all Georgians.

Vision:
We strengthen local food communities by empowering networks of farmers to facilitate access to and awareness of healthy food choices.

Programs:

- Georgia Fresh For Less
- Fruit and Vegetable Prescription (FVRX) Program
- Snap Enrollment
- Partnerships (Portal)

Atlanta Regional Commission
Atlanta Local Food Initiative (ALFI)

atlantaregional.org/natural-resources/sustainability/natural-resources-sustainability-atlanta-local-food-initiative/

ALFI Vision and Mission:
The Atlanta Local Food Initiative (ALFI) is a diverse coalition of stakeholders who are working to build a more sustainable food system for metro Atlanta. The stakeholder group includes communities, nonprofits, universities, government agencies, individuals and corporations. ALFI envisions a transformed food system in which every metro Atlanta resident has access to safe, nutritious and affordable food produced by a thriving network of sustainable farms and gardens.

Healthy Food Resources (continued)	
Atlanta Community Food Bank 732 Joseph E. Lowery Blvd., NW, Atlanta, GA 30318. Second Location 970 Jefferson St., NW, Atlanta, GA 30318. Agency Locator for Metro Atlanta: www.acfb.org/local-impact-map	The mission of the Atlanta Community Food Bank is to fight hunger by engaging, educating and empowering our community. While our core work is food distribution, our efforts extend far beyond that. Our mission is lived out every day through seven projects that help engage, educate and empower both people in need and those who want to help. From supporting community gardens to assisting people in finding economic security, the Food Bank covers a wide range of opportunities for people to learn and get involved. Our seven projects are Atlanta Prosperity Campaign, Atlanta's Table, Community Gardens, Hunger 101, Hunger Walk/Run, Kids In Need and Product Rescue Center.
Additional Resources	
Cobb Collaborative 770-514-7213 communications@cobbcollaborative.org www.cobbcollaborative.org/	Who we are: Cobb Collaborative is a membership of nonprofit organizations, local government, businesses, faith-based organizations, educational institutions, professional organizations, associations and citizens who share ideas, expertise and resources to meet the needs of Cobb County. Our mission: To convene community stakeholders to facilitate the sharing of ideas, expertise and resources to strengthen the non-profit community.
2040 Cobb Comprehensive Plan	The Comprehensive Plan is a long-range, community-designed growth strategy that will continue to make Cobb County an attractive place to invest, conduct business, and raise a family. The current plan, adopted in 2017 with subsequent annual amendments, covers the time period between 2017 and 2040.
Smoke Free Georgia Coalition: Tobacco Prevention	The Smoke Free Georgia Coalition is a group of state and local organizations committed to the pursuit of a 100% tobacco-free Georgia. Achieving optimal health for Georgia citizens requires community members to collectively stand for the environmental changes that make living smoke free lives as easy as possible. To this end, we promote efforts aimed at creating smoke-free policies in schools, restaurants and bars, hospitals, parks, workplaces and public housing. We also encourage creative ideas for educating the public about the harms of secondhand smoke and preventing youth initiation of tobacco, including hookah.
Loudermilk Conference Center 40 Courtland St NE, Atlanta, GA 30303	The Loudermilk Conference Center provides flexible meeting and event spaces that can accommodate groups up to 500 people. We have a lobby/exhibit hall, large ballroom, amphitheater and boardroom, all with built-in technology and WiFi.
University of Georgia Extension Office of the Associate Dean for Extension, College of Agricultural and Environmental Sciences, 111 Conner Hall, Athens, GA 30602 coopext@uga.edu 706-542-1060 1-800-ASK-UGA1 Search for your County Office: extension.uga.edu/county-offices.html	For over 100 years, University of Georgia Cooperative Extension has provided free, reliable, research-based information based on latest the scientific research in language that anyone can understand. Our experts deliver information via: ■ programs and workshops, ■ field days, ■ blogs, newsletters and mass media, ■ phone call and in-person consultations, and ■ print and online publications.

Maternal and Child Health

Prevent Child Abuse – Georgia State University School of Public Health 14 Marietta Street NW, Suite 100, P.O. Box 3995, Atlanta, GA 30303	Prevent Child Abuse America, founded in 1972, is focused on changing the way our nation thinks about prevention, focusing on community activities and public policies that prioritize prevention right from the start to make sure child abuse and neglect never occur. PCA works to ensure the healthy development of children nationwide while recognizing that child development is a building block for community development and economic development.
Families First 80 Joseph E. Lowery Boulevard, NW, Atlanta, GA 30314 (404) 853-2800	Families First is Georgia's largest family and children's services organization in metro Atlanta. We work to improve outcomes for youth at every stage of life by providing them with mental health support, mentorship, early education, and supportive housing and strengthening families no matter what challenges they may be facing.
Oak Hill Child, Adolescent and Family Health Center 2805 Metropolitan Parkway, Atlanta, GA 30315 404-612-4111	Children's Medical Services (CMS) works to provide improved health outcomes for children with special health care needs from birth to the age of 21-years. CMS coordinates access to affordable, quality, specialty health care services in local Fulton County communities. Services provided: ■ Comprehensive Physical Evaluations ■ Diagnostic Tests ■ Inpatient/Outpatient Hospitalization ■ Medications & Other Medical Treatments ■ Therapy ■ Durable Medical Equipment ■ Hearing Aids Related to the Child's CMS-Eligible Condition ■ Genetic Counseling
Georgia Department of Public Health Maternal and Child Health Section 2 Peachtree Street, NW, 11th Floor, Atlanta, GA 30303 404-657-2850 Healthy Mothers, Healthy Babies PowerLine: 800-300-9003 www.resourcehouse.com/hmhb/	Georgia's Maternal and Child Health (MCH) Section is housed within the Division of Health Promotion in the Georgia Department of Public Health. MCH is the State agency responsible for administering the Federal Title V Maternal and Child Health Block Grant. Policy development and programmatic direction is provided by the MCH Office Staff with input from families, providers and partners; direct services are delivered by the 18 District Health Departments representing 159 counties in Georgia. Available Programs: ■ Babies Can't Wait ■ Children's Medical Services ■ Perinatal Case Management ■ Regional Perinatal Coordinators ■ Women's Health Coordinators ■ Health Departments – Newborn Screening ■ Children 1st ■ Early Hearing Detection and Intervention ■ Oral Health Program ■ Sexually Transmitted Diseases ■ GAAC Autism Specialty Clinic ■ GA Home Visiting

Implementation Plan

Building a Culture of Health

This Implementation Plan for WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a Community Health Needs Assessment (CHNA) at least once every three years and adopt an Implementation Plan to meet the community health needs identified through the CHNA written reports per hospital facility. This Implementation Plan is intended to satisfy each of the applicable requirements set forth in proposed regulations.

Background

After an analysis of primary and secondary data gathered for the 2019 WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals Community Health Needs Assessment (CHNA), priority health needs were identified at a Community Health Summit. This Summit was comprised of a broad spectrum of hospital leaders and community stakeholders. Using current assets/capacity measures[1] as key indicators to improve community health, the summit participants answered this overriding question reflecting the patient-centered Triple Aim[2] framework: Which health needs, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the health of the community, especially the under-resourced?

To deliver more comprehensive, collaborative and value-based community benefit initiatives, services, education and events, a task force, the WellStar Community Health Collaborative (WCHC), was created in the fall of 2016 at the system level to address Legacy WellStar's priority health needs.[3]

The WCHC is now expanded to encompass all WellStar hospital communities after the April 2016 acquisition of six hospitals in Georgia, five of which were converted to not-for-profit in 2017, including WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals. This cross-functional task force enables WellStar to better implement community benefit initiatives and measure outcomes of collaborative efforts to improve community health.

1 *Other considerations: (1) The burden, scope, severity, and urgency of the need. (2) The estimated feasibility and effectiveness of possible interventions. (3) Health disparities associated with the need or the importance the community places on addressing the need.*

2 *The Institute of Healthcare Improvement's (IHI) "Triple Aim" framework to optimize a health system's performance: (1) Improve the patient care experience (2) Improve the health of a population (3) Reduce healthcare costs.*

3 *Legacy WellStar is defined as the community where WellStar Cobb Hospital, WellStar Douglas Hospital, WellStar Kennestone Hospital, WellStar Paulding Hospital and WellStar Windy Hill Hospital are located. Legacy WellStar is the entity prior to the acquisition of WellStar West Georgia Medical Center and former Tenet hospitals — WellStar Atlanta Medical Center and Atlanta Medical Center South, WellStar North Fulton Hospital, WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital.*

WCHC ensures that WellStar's community benefit initiatives are designed to:

- Provide organization, framework and leadership to the delivery of community benefit services, which enables WellStar to more effectively evaluate and measure the impact on community health,
- Strengthen WellStar's strategic community partnerships in public and private sectors through formalized engagement that leverages shared expertise, resources and services to help build capacity, bridge intervention gaps and address health disparities,
- Boost WellStar's ability to replicate and deliver community benefit services across an expanding health system footprint,
- Maximize the investment in WellStar's safety-net clinic/nonprofit partners by better aligning our services and resources to address priority health needs and
- Improve overall community health, especially among the under-resourced community members.

Review of Priority Health Needs

Leaders of Georgia State University's Georgia Health Policy Center helped guide WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals through the prioritization process at the Health Summit. From the significant health needs identified by CHNA research conducted, the following health needs were valuated as priority for the community WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals serve:

Implementation strategies for each need were recommended during group exercises. The strategies were later reviewed by WellStar's Senior leadership and vetted by the WellStar board of trustees' Community Advocacy and Engagement Committee and the WCHC task force, the conduits for system-wide delivery of community health improvement services and education.

Action areas for implementation to improve community health are influenced by the full spectrum of the public health system, in which WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals play a vital role:[4]

Socioeconomic Factors: Interventions that address social determinants of health, such as income, education, occupation, class or social support. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age. These determinants contribute to a wide range of health, functioning and quality of life outcomes.

Physical Environment: Interventions addressing structural and environmental conditions that have an impact on health, including the built environment, as well as the community environment. This category includes policy changes that support individuals in making healthy choices.

Health Behaviors: Interventions that promote and reinforce positive individual health behaviors and seek to enable people to increase control over their health and its determinants. They include actions that address the knowledge, barriers and facilitators that can affect behavior.

Clinical Care: Innovative interventions focused on clinical approaches to health improvement that go beyond traditional one-on-one patient care. These activities are upstream or systems-based, and include examples of clinical providers working in teams or providing direct care in a non-traditional setting.

4 *Centers for Disease Control and Prevention, Community Health Improvement Navigator tool. http://wwwn.cdc.gov/chidatabase*

The scope of WellStar's healthcare footprint and its commitment to its mission makes WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals linchpins and integrators in the community for delivering care, interventions and education to improve overall population health and health equity in the community we serve. This involves providing community benefit programming to address priority health needs via collaborative partners who provide care access, services and resources to under-resourced populations.

Health Needs Addressed

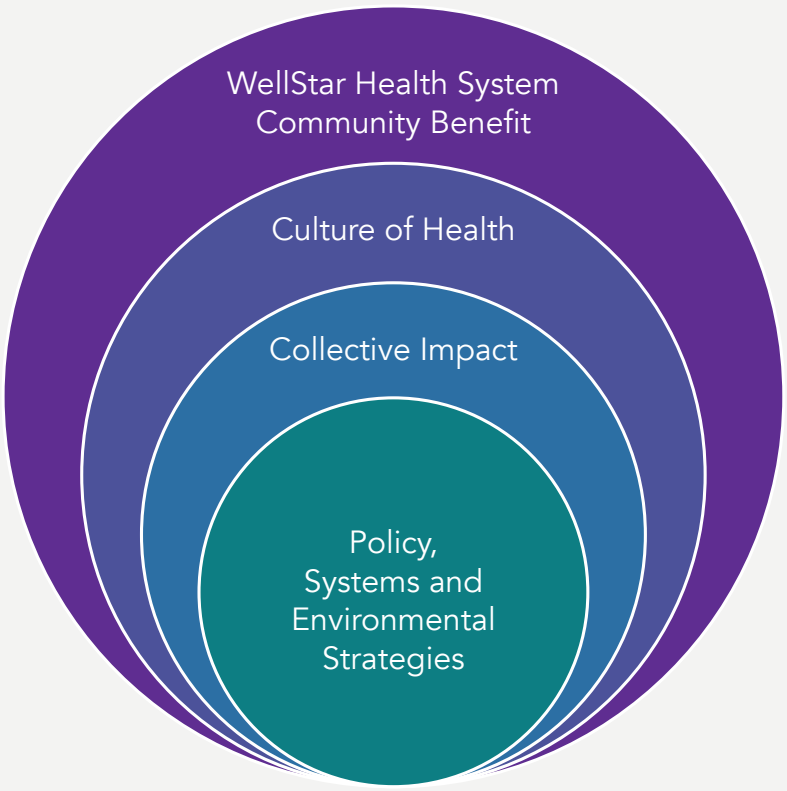
	Access to appropriate care	Chronic disease	Behavioral health	Substance abuse	Maternal and child health
Cancer Prevention and Screening	■	■			
Community Education & Outreach	■	■	■	■	■
Community Transformation Grants	■	■	■	■	■
Public Health Policy and Advocacy	■		■	■	■
Screening for Food Insecurity	■	■			
The Health of All Women	■	■			■
WellStar 4-1 Care	■				
WellStar Day of Service	■	■	■	■	■
WellStar Opioid Steering Committee	■	■	■	■	
WellStar Research Institute	■				■
Zero Suicide Initiative	■	■	■		

Implementation Plan Framework and Guiding Principles

To address the priority health needs of the 2019 CHNA, WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals are initiating and adapting components of the Robert Wood Johnson Culture of Health Framework with influence from the Collective Impact approach and policy, systems and environmental (PSE) change strategies. The aim is to proactively transform data-driven CHNA results into actionable and measurable community benefit programs and services to optimize patient outcomes and improve overall community health.

These efforts flow from the WellStar mission and vision, and to meet the requirements of the federal government (Affordable Care Act Section 9007) of systemwide oversight and guidance regarding tracking community benefit activities, assessing community health needs and developing strategic plans that prioritize the delivery of community benefit.

Framework and Guiding Principles



Evidenced-Based Framework, Research-Based Recommendations and Public Health Policy were used to anchor the Implementation Plan in proven strategies to improve community health.

The Robert Wood Johnson Culture of Health Framework is informed by rigorous research on the multiple factors that affect health. It recognizes the many ways to build a Culture of Health and provides numerous entry points for all types of organizations to become collaborative Partners in Health.[5,6]

5 *https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html*

6 *A critical aspect of a Culture of Health is health equity, which in essence means we all have the basics to be as healthy as possible. Yet at present, for too many, prospects for good health are limited by where we live, how much money we make or discrimination we face.*

Culture of Health Action Framework

To achieve better health for all, the Culture of Health framework leverages the interconnection of health and social issues, the link between population well-being and life expectancy and collaboration across many different sectors.[7]

A Culture of Health will not be achieved by focusing on each action area alone, but by recognizing the interdependence of each area. Implementing the framework will take time and involve collaboration across multiple sectors beyond the traditional public health field.

Adopting this Culture of Health framework, with health equity at the center, will inform every aspect of community benefit at WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals — from our safety-net clinic partnerships and community grant focus areas to the types of initiatives funded and how we assess the effectiveness of programs and services addressing priority health needs.

Health Equity Pledge

At WellStar Health System, we strive and commit to achieving healthcare equity and eliminating healthcare disparities across our diverse communities we serve. In 2017, WellStar Health System signed the American Hospital Association Health Equity Pledge, which aligns with the CHNA Implementation Plan. Recognizing that there are areas for improvement is a first step, but it must be followed by actionable strategies and tactics to make sustainable improvements. The 2019 CHNA demonstrated the impact and complexities of health disparities as they are affected by factors related to individuals, communities, society, culture, and the environment. In alignment with the Health Equity Pledge, WellStar's CHNA Implementation Plan emphasizes cross-sector collaboration to plan and carry out strategies that provide impact to local communities. These collaborations will seek to actively engage those most affected by disparities in future identification, design, implementation and evaluation of promising solutions. An equity-focused system of health offers everyone an opportunity to have a healthy life regardless of race, gender, culture or income.

7 *Building a Culture of Health https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html*

There are four Action Areas with 12 underlying principles for the Culture of Health framework:

Action Area 1: Making Health a Shared Value: How can individuals, families and communities work to achieve and maintain health?		
Underlying Principles:		
Mindset and Expectations Prioritizing and promoting health and well-being	**Civic Engagement** Participating in activities that advance the public good	**Sense of Community** Cultivating social connections that help us thrive

Action Area 2: Fostering Cross-Sector Collaboration: How can we encourage cooperation across all sectors?		
Underlying Principles:		
Quality of Partnerships Organizations working together and seeing successful outcomes	**Investment in Collaboration** Adequate financial support to enable more successful partnerships	**Policies that Support Collaboration** Creating incentives and methods to encourage ongoing coordination

Action Area 3: Creating Healthier, More Equitable Communities: How can we develop safe environments that nurture children, support aging adults and offer equitable access to healthy choices?		
Underlying Principles:		
Built Environment Creating safe, affordable environments that support our well-being	**Social and Economic Environment** Providing improved public resources and economic opportunity for everyone	**Policy and Governance** Establishing policies to create healthy environments through collaboration

Action Area 4: Strengthening Integration of Health Services and Systems: How can healthcare providers work with institutional partners to address the realities of patients' lives?		
Underlying Principles:		
Access to Care Making comprehensive, continuous care and healthy choices available to all	**Balance and Integration** Improving care when public health, social services and healthcare systems work together	**Consumer Experience** Providing safe, equitable, accessible, efficient and timely care

Collective Impact Approach

Collective Impact is an approach to tackle deeply entrenched and complex social problems like social determinants of health. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change.

The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. The approach calls for multiple organizations or entities from different sectors to adopt a common agenda, shared measurement and alignment of effort.

WellStar recognizes and values our partnerships with local public health departments and organizations. These entities have a longstanding commitment to addressing the top contributors to disparities in morbidity and mortality rates in Georgia and providing opportunities for WellStar to provide comprehensive, community-based health initiatives. Improvement in long-term health outcomes requires that these relationships are sustained beyond the CHNA process. Therefore, WellStar remains an active partner on a variety of public health task forces and initiatives.

Collective Impact Approach

Collective Impact is a systemic approach to social impact that focuses on the collaborative relationships between organizations and the progress toward shared objectives. The five conditions that drive this approach work together to produce true alignment and can lead to powerful results.[8]

8 *Stanford Social Innovation Review (2011) Retrieved from: https://ssir.org/articles/entry/collective_impact*

Policy, Systems and Environmental Change Strategies

Policy, systems and environmental (PSE) change is a way of modifying the environment to make healthy choices practical and available to all community members. PSE changes in communities, schools, workplaces, parks, transportation systems, faith-based organizations and healthcare settings can significantly shape lives and health. Access to affordable fruits and vegetables, design of sidewalks and bike lanes within communities, and smoke-free policies in workplaces and businesses directly increase the likelihood that people can eat healthy and nutritious food, walk to school or work and avoid exposure to second-hand smoke.[9]

PSE changes in communities that make healthy choices easy, safe and affordable can have a positive impact on the way people live, learn, work and play. Cross-sector partnerships with community leaders in education, government, transportation and business are essential in creating sustainable change to reduce the burden of chronic disease. PSE change is instrumental in creating and encouraging healthy behaviors in the community that WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals serve.

Defining Policy, Systems and Environmental Change†

Type of Change	Definition
Policy	Interventions that create or amend laws, ordinances, resolutions, mandates, regulations or rules
Systems	Interventions that impact all elements of an organization, institution or system
Environmental	Interventions that involve physical or material changes to the economic, social or physical environment

† *National Association of County and City Health Officials*

Implementation Plan to Address Priority Health Needs

WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals are dedicated to improving the health of the community we serve. With the unique needs identified by our community partners and consideration given to the Culture of Health Framework, the Implementation Plan focuses on two key areas.

Two-Pronged Approach	
1. Community-Driven Solutions	Partnering with communities to drive locally determined solutions and policies that influence systems, services and practices to create equitable conditions that improve well-being. Improving these conditions promotes health equity among people in low-income neighborhoods and fosters health for the hospitals' community.
2. Sustainable Infrastructure	Building community benefit capacity and competency within WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals to streamline business practices and reporting.

9 *Centers for Disease Control and Prevention. (2011). Policy, Systems and Environmental Change. Retrieved from http:// www.cdc.gov/communitiesputtingpreventiontowork/policy/ index.htm#strategies.*

Community-Driven Solutions		Sustainable Infrastructure
Community Education & Outreach	Moving Upstream: WellStar Community Transformation Grants and Day of Service	Screening for Food Insecurity
WellStar 4-1 Care	WellStar Opioid Steering Committee	Hospital's Roles and Responsibilities
Zero Suicide Initiative	The Health of All Women	Public Health Policy and Advocacy
Cancer Prevention and Screening		WellStar Research Institute

Community-Driven Solutions:

Community Education & Outreach

To address the priority health needs identified in the CHNA, WellStar's Community Education & Outreach (CE&O) Department plays an integral role in the Implementation Plan. In addition to supporting community programs and services provided by other non-profit organizations, CE&O provides several signature community programs and initiatives that benefit our communities. These programs and initiatives focus on health and wellness programs and services in community and worksite settings, to targeted populations, to improve the health, safety and well-being of the individuals we serve.

In addition, CE&O has built a tremendous network of strategic community partnerships on behalf of WellStar to collectively impact the health status of our community. These partnerships include both internal and external community partners, such as community safety-net clinics, congregations, schools and other community-based organizations and companies serving under-resourced populations. Through these programs, services and partnerships, WellStar strategically improves the overall health and well-being of individuals and communities.

Programmatic Productivity
Number of innovative, evidenced-based health education classes and programs related to health promotion and disease prevention to enhance health
Number of participants in innovative, evidenced-based health education classes and programs related to health promotion and disease prevention to enhance health
Number of community events and programs completed
Number of prevention screenings completed

Programmatic Outcomes
Percentage of participants who are willing to recommend future community education activities and classes to others
Percentage of participants who comprehend concepts related to health promotion and disease prevention to enhance health
Percentage of participants who demonstrate the ability to use decision-making skills to enhance health
Percentage of participants who demonstrate the ability to practice health-enhancing behaviors
Percentage of participants who demonstrate changes in their health behaviors
Community partner and participant satisfaction score
Investment in community programs, events and partnership and sponsorship efforts that address a priority health need

Signature Community Programs and Initiatives that Address Priority Health Needs	
Community Education, Screening and Prevention	
Speaker Series and Speakers' Bureau	WellStar's Speaking about Wellness Program provides our community with multiple speaker series and a robust speakers' bureau focused on preventative health and wellness education topics for all life stages. The speaker series component includes: Speaking about Wellness for Healthy Aging and Speaking about Wellness for Women/Spirit of Women®. The speakers' bureau includes: Speaking about Wellness for the Community and Speaking about Wellness for the Workplace.
School Health Programs	WellStar's School Health Program partners with local elementary and middle schools to provide interactive lessons on nutrition, physical activity, Internet safety, anger management, dental health, wheel/passenger safety, water safety, personal hygiene and poison prevention.
Worksite Wellness	WellStar's Worksite Wellness Program encourages a proactive approach to healthcare by providing the convenience of on-site health and wellness resources to small and medium-sized businesses, customized to meet employers' and employees' specific needs. Services include health screenings, CPR/First Aid training and Speaking about Wellness for the Workplace.
Screenings and Prevention	WellStar's Screening and Prevention Program provides health education and health screenings for community members and organizations. This program promotes health, assists in preventing disease and offers early detection.
Good Life Club	WellStar's Good Life Club is an organization for people 50 and older who want to learn how to live better, be healthier and stay active. The program focus is on healthy aging, including wellness, health education, travel and social activities.
Medication Take-Back	WellStar's Medication Take-Back events are a partnership between WellStar Community Education & Outreach, local police departments and community-based organizations to provide secure drop-off locations for expired and unused medications.
Advance Care Planning Workshops	WellStar's Ethics Steering Committee, Congregational Health Network and CE&O collaborate to provide workshops where participants learn how to talk with loved ones about final healthcare decisions. Each participant receives a free planning guide outlining questions he/she should discuss with family members, as well as forms to record wishes.
Safe Kids Cobb	The Safe Kids program is committed to reducing and preventing injuries to children by hosting safety education events and distributing safety equipment throughout the county. Program equipment, including car seats, bike helmets, life jackets and more, is funded in partnership with the WellStar Foundation.
Congregational Health Network	WellStar's Congregational Health Network serves as a bridge between our healthcare system and faith communities. Coordinated by a full-time registered nurse who specializes in faith community nursing, WellStar's program is designed to assist congregations of all faiths to develop or support volunteer or paid health ministries.
CPR and First Aid Classes	WellStar works in partnership with the American Heart Association to provide CPR and First Aid classes in community, congregation and corporate settings. Classes included are Family & Friends CPR and Hands-Only CPR.
Community Outreach	
Community Events	WellStar Health System participates in a wide variety of community events throughout the year, including health fairs, expos, road races, festivals, farmers' markets, community walks, congregation events/health fairs and special signature events such as WellStar's Spirit Girls' Night Out.
Community Partnerships	Community Education & Outreach is responsible for developing and cultivating strategic community partnerships. Partnerships allow us to focus on prevention and wellness, impact community priority health needs and increase access to healthcare services.
Community Sponsorships	WellStar Health System supports the health and wellbeing of the communities we serve by actively engaging in sponsorship opportunities. Each year, WellStar supports other nonprofit organizations that align with our mission, vision and community needs assessment to improve the health of citizens in our communities.

Community-Driven Solutions:

Moving Upstream: WellStar Community Transformation Grants and Day of Service

WellStar Health System is committed to building meaningful partnerships with community-based organizations that are addressing the priority health needs of the communities we serve.

As an anchor institution, WellStar is poised to catalyze change, in collaboration with other local partners, in the various conditions that influence health outcomes from education to economic development to the environment, and beyond. Research has shown that anchor strategies can result in the following:[10]

- Lower hospital readmission rates
- Improve employee engagement and satisfaction through stronger community connections
- Further align capital with sustainability, diversity and inclusion, and community benefit priorities
- Create more meaningful connections with our community to build reputation of trust
- Create more meaningful connections with other place-based anchor institutions

As an anchor, WellStar can address a wide range of health, functioning and quality-of-life outcomes and risks by doing the following:[11]

- Place-Based Investment: Designate resources to make local financial investments that specifically address social determinants of health that are identified as barriers in the 2019 CHNA
- Upstream Community Benefit: Address community health needs by allocating people and time resources to support organizations that are implementing initiatives and interventions that address social determinants of health

Therefore, WellStar is launching two new place-based initiatives: the Community Transformation Grant Program and WellStar Day of Service. Both programs focus on policy, systems and environmental (PSE) change that address social determinants of health.

The Community Transformation Grant Program is an annual, competitive micro-grant program that will invest in the capacity of community-based organizations that are implementing PSE changes. This investment will focus on PSE changes that will improve programmatic effectiveness and future sustainability.

10 Placed-Based Investing: Creating Sustainable Returns and Strong Communities Toolkit. Retrieved from https://hospitaltoolkits.org/investment/

11 Norris T & Howard T (nd). Can Hospitals Health America's Communities. Retrieved from https://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/CanHospitalsHealAmericasCommunities.pdf

WellStar Day of Service will create a conduit for WellStar employees to support local, community-based organizations that are addressing social determinants of health. By investing time and resources, Day of Service will support programmatic operations, as well as PSE changes, that will help community-based organizations advance their mission.

Finally, these strategies align with the Robert Wood Johnson Culture of Health Framework and recommendations from the American Hospital Association which emphasize the importance of making health a shared value and cross-sector collaboration as essential entry points for WellStar to become a partner in health. [12, 13]

Programmatic Productivity
Create small and large grant opportunities for eligible organizations to develop and offer innovative programs supporting the mission of improving health outcomes in the WellStar communities
Evaluate and disseminate the impact of health initiatives, programs and investments
Create systemwide employee volunteer opportunities that can accommodate 1,000-plus WellStar employees
Assessment of what the partnership is lacking to truly be effective
Partner satisfaction with WellStar's level of engagement
Partner satisfaction with WellStar's role in partnership

Programmatic Outcomes
Increase in organizational capacity after WellStar investments
Hospital readmissions rates for intervention population
Intervention population has increased access to the support services that they need to address preventable chronic conditions and behavioral health issues
Percentage and number of WellStar leadership volunteering for a local community-based organization addressing social determinants of health
Percentage and number of WellStar employees volunteering for a local community-based organization addressing social determinants of health
Volunteer hours donated to increasing the capacity of community-based organizations that are addressing food access and food insecurity needs
Estimated dollar value of hours donated to increasing the capacity of community-based organizations that are addressing food access and food insecurity needs

12 *Robert Wood Johnson (2014). Hospital-based Strategies for Creating a Culture of Health. Retrieved from https://www.rwjf.org/en/library/research/2014/10/hospital-based-strategies-for-creating-a-culture-of-health.html*

13 *American Hospital Association (2016). 2016 Committee on Research Next Generation of Community Health. Retrieved from https://www.aha.org/system/files/2018-03/committee-on-research-next-gen-community-health.pdf*

Community-Driven Solutions:

WellStar 4-1 Care

According to the 2019 CHNA access to care indicators, many members of WellStar's community have care access challenges in large part due to insurance constraints and provider access shortages. According to Healthy People 2020, "Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity.[14] WellStar is committed to serving our community's most vulnerable and under-resourced populations. In 2016, WellStar 4-1 Care was created to increase access to care and the capacity of partnering community clinics by providing reduced-cost outpatient medical services. Research has shown that when healthcare systems, like WellStar, partner with community safety-net clinics the following can occur.[15, 16]

- Reduction in Emergency Department Visits
- Reduction in Avoidable Readmissions
- Increase in Patient Satisfaction Scores
- Prevent illness by promoting healthy behaviors in people without risk factors (e.g., diet and exercise counseling)
- Prevent illness by providing protection to those at risk (e.g., childhood vaccinations)
- Identify and treat people with no symptoms, but who have risk factors, before the clinical illness develops (e.g., screening for hypertension or diabetes)

Evolution of WellStar 4-1 Care

The WellStar 4-1 Care program will evolve to advance WellStar's ability to support community access to care and social support services. As WellStar's geographical footprint has expanded, WellStar is also committed to forging new partnerships with community clinics (i.e. Community Safety-Net Clinics, Community Health Centers and Federally Qualified Health Centers) to more collectively achieve optimal outcomes for more medically underserved and uninsured residents.

14 *Healthy People 2020 (n.d.). Access to Health Services. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services*

15 *Health Research & Educational Trust. (2016, August). Creating effective hospital-community partnerships to build a Culture of Health. Chicago, IL: Health Research & Educational Trust. http://www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf*

16 *Parker, Amanda, "A Program Evaluation of a Peri-Urban, Multi-Location Care Coordination Program in Georgia and Comparative Analysis of Other United States Care Coordination Programs for Uninsured, High-Risk Patients to Develop Promising Practice Recommendations." Georgia State University, 2017. Retrieved https://scholarworks.gsu.edu/iph_capstone/44*

In addition, WellStar 4-1 Care will evolve to include community benefit support of WellStar's three Community Clinics—WellStar AMC Sheffield Community Clinic, WellStar Kennestone Community Clinic and WellStar West Georgia Community Service Clinic. In alignment with WellStar's Financial Assistance Program (FAP), these community-based clinics provide charitable discounted or free care based on socioeconomic factors like a patient's household income, insurance status and/or family size and household income. These clinics help some of WellStar's most under-resourced and vulnerable community members receive medical services like chronic disease management, wellness exams, vaccinations and medication counseling. In partnership with physician leadership, Graduate Medical Education (GME) residents serve patients at the Sheffield and Kennestone clinics. To support these WellStar GME residents, as a part of WellStar 4-1 Care, structured education will be provided to help residents better understand health disparities, health equity and community health priorities. Through 4-1 Care, WellStar will continue to leverage that community-based clinics are long recognized for their ability to effectively improve and expand patient access to medical, dental and mental health services.

Programmatic Productivity
Develop and complete formal memorandums of understanding (MOUs) between (i.e. Community Safety-Net Clinics, Community Health Centers and Federally Qualified Health Centers) and WellStar Health System
Number of WellStar 4-1 Care partnering community clinics (i.e. Community Safety-Net Clinics, Community Health Centers and Federally Qualified Health Centers)
Develop a Multifaceted Health Disparities Curriculum for Medical Residents
Number of patients served by WellStar Community Clinics
Assist with government-sponsored health insurance enrollment and applications for WellStar's Financial Assistance Program and promote awareness on-site at the hospital
Number of Community Clinic patients that complete Financial Assistant Program applications

Programmatic Outcomes
Investment in community clinics' operational needs
Percentage of residents who report increased preparedness and skill caring for vulnerable patients
Hospital readmissions rates for intervention population
Patient satisfaction scores for intervention population

Community-Driven Solutions:

WellStar Opioid Steering Committee

WellStar's Opioid Steering Committee is planning and implementing an ongoing comprehensive and collaborative response to the public health emergency of opioids by leading and collaborating with WellStar providers, patients and communities to help reduce opioid misuse, abuse and addiction.

Three physician-led work groups committed to prevention, treatment and recovery, champion the steering committee's efforts. Work groups target various populations internally (team-based) and externally (community-based): (1) provider and patient education, (2) clinical initiatives and (3) community awareness and engagement.

This committee is working to limit access to opioids by implementing alternative treatment order sets and care pathways for acute or chronic pain management, educating providers and patients on the risks of opioids and collaborating with community partners for advocacy and awareness events and activities. In addition, this committee is to navigate high-risk patients and community members with a history of long-term opioid use, as well as those struggling with misuse, abuse or addiction, toward safer treatment modalities and behavioral health resources to achieve optimal rehabilitation and recovery outcomes. Finally, the Opioid Steering Committee collaborates with CE&O to increase community awareness through the expansion of the Medication Take Back Day program and strengthening partnerships with community organizations, resources, government, law enforcement and first responders.

Programmatic Productivity
Identify best practices and quality measures to prevent opioid use and overprescribing
Number of provider education sessions that support opioid stewardship
Evaluate team-based prescription practices and community opioid abuse, overdose and addiction rates
Number of new clinical initiatives targeting improved opioid stewardship
Assess the availability and accessibility of behavioral health and substance abuse treatment services and other community and government resources for long-term recovery
Number of education and events conducted in WellStar communities on the risks of opioid use with a focus on teens and parents
Number of opioid prescriptions per 100 prescriptions (measuring across the system, by specialty, by hospital and by provider)
Tracking the morphine equivalence daily dose (MEDD) to reduce the percentage of high-dose opioid prescriptions
Promote public policies that support the prevention, treatment services and recovery programs that make the most impact on community health as it relates to opioid misuse
Programmatic Outcomes
Weight of medications collected through the Medication Take Back Day events
Investment in community programs, events and partnership and sponsorship efforts that address behavioral health and substance abuse

Community-Driven Solutions:

Zero Suicide Initiative

WellStar Health System has committed to implement components of the Zero Suicide framework, which will be a system-wide, organizational commitment to safer suicide care.

Inspired by health care systems that saw dramatic reductions in patient suicide, Zero Suicide began as a key concept of the 2012 National Strategy for Suicide Prevention, and quickly became a priority of the National Action Alliance for Suicide Prevention (Action Alliance) and a project of Education Development Center's Suicide Prevention Resource Center (SPRC), supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The framework is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted healthcare system. A systematic approach to quality improvement in these settings is both available and necessary.

The Zero Suicide framework equips mental health professionals and direct care staff with knowledge of suicidality signs and the necessary next steps, in the event of an unexpected mental health episode.[17] Research shows that implementing comprehensive screening and assessment tools is more effective than clinicians' judgement alone and allows for a better evaluation of risk factors prior to treatment strategy preparation.[18] If treatment is needed, dialectical behavior therapy has shown to decrease treatment attrition, suicide attempts, hospitalization and treatment received from the ED.[19] Furthermore, delegation of patient safety planning requires care management measures, e.g. follow-up contact with patients. Studies show that improving continuity of care by contacting patients post-discharge reduces suicidal ideations and behavior, and the rate of suicide.[20]

For health care systems, this approach represents a commitment to patient safety, the most fundamental responsibility of health care, and the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

17 *Schmitz WM, Allen MH, Feldman BN, Gutin NJ, Jahn DR, Kleespies PM, et al. Preventing suicide through improved training in suicide risk assessment and care: an American Association of Suicidology Task Force report addressing serious gaps in U.S. mental health training. Suicide Life Threat Behav. 2012; 42 (3): 292 – 304.*

18 *Posner K, Brown GK, Stanley B, Brent DA, Yershova K , Oquendo MA, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. Am J Psychiatry. 2011; 168 (12): 1266 – 77*

19 *Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry. 2006; 63 (7): 757 – 66*

20 *Suicide prevention strategies revisited: 10-year systematic review. Zalsman G, Hawton K, Wasserman D, van Heeringen K, Arensman E, Sarchiapone M, Carli V, Höschl C, Barzilay R, Balazs J, Purebl G, Kahn JP, Sáiz PA, Lipsicas CB, Bobes J, Cozman D, Hegerl U, Zohar J Lancet Psychiatry. 2016 Jul; 3(7):646-59.*

Programmatic Productivity
Establish the Zero Suicide framework as a WellStar Health System initiative to address behavioral health needs of the community
Number of trainees that complete Zero Suicide Gatekeeper Training: Question, Persuade and Refer (QPR)
Number of Zero Suicide Training: Question, Persuade and Refer (QPR) classes offered
Number of Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy – Suicidal Patients (CBT-SP), and Collaborative Assessment and Management of Suicidality (CAMS)
Safety Planning Intervention (SPI) offered to providers in the community
Number of trainees that complete Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy – Suicidal Patients (CBT-SP), Safety Planning Intervention (SPI) and Collaborative Assessment and Management of Suicidality (CAMS)
Number of established community behavioral healthcare and support resources and partnerships

Programmatic Outcomes
Trainees demonstrate an increase in understanding in symptoms of common mental illnesses and substance use disorders based on pre- and post-testing
Trainees demonstrate the skills and ability to conduct a timely referral to mental health and substance abuse resources available in the community based on pre- and post-testing

Community-Driven Solutions:

The Health of All Women

WellStar Health System is committed to providing comprehensive care for women across all life stages within the communities we serve. To address the priority health needs identified in the CHNA process, WellStar Women's Health will address maternal and infant health needs through clinical practices, patient education and community outreach.

Clinical practices have established system-level continuous improvement councils that are both physician and nurse led. These system-level councils monitor clinical practices throughout WellStar Health System and implement care models with evidence-based policies, procedures, protocols and pathways, while local interdisciplinary councils monitor Women's Health practices on-site in individual WellStar hospitals. WellStar Women's Health will also implement a standardized, evidence-based framework to ensure clinical quality in obstetrics. These quality assurance measures will include some of the most common, nationally recognized causes of maternal mortality, such as hypertensive disorders and obstetric hemorrhage. These efforts will influence the care of approximately 45,000 mothers and their babies born at WellStar facilities within the next three years. The implementation of these quality assurance measures has resulted in significant improvements in maternal obstetric hemorrhage, hypertensive crisis and preeclamptic-related injury rates, along with infant birth injury rates, in other organizations similar to WellStar Health System nationwide.

WellStar Women's Health Service Line is expanding its Women and Children Resource Center patient education offerings to reach more than 15,000 families annually. The Women and Children Resource Center provides support for mothers, families and their newborn babies through perinatal support services, family education and breastfeeding support education classes. Also, the WellStar Women's Health Service Line and the CE&O Department will continue to collaborate on initiatives and programs to support prevention education and screenings. The U.S. Preventive Services Task Force (USPSTF) recommends interventions during pregnancy and after birth to promote and support breastfeeding.[21] Evidence suggests that breastfeeding has a positive influence on infants and children (e.g., protection against childhood obesity, type 2 diabetes, asthma and certain types of infections) and women by reducing the prevalence of breast and ovarian cancers, maternal hypertension, diabetes and cardiovascular disease.[22]

21 *US Preventive Services Task Force. Primary care interventions to promote breastfeeding: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2008;149(8):560-564.*

22 *Ip S, Chung M, Raman G, et al. Breastfeeding and maternal and infant health outcomes in developed countries. Evid Rep Technol Assess (Full Rep). 2007;(153):1-186.*

WellStar Women's Health has established a postpartum subcommittee charged with establishing and implementing postpartum screening, follow-up and referral practices for at-risk mothers and babies. The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions. Compared with controls, counseling interventions were associated with a lower likelihood of an onset of perinatal depression.[23]

Finally, WellStar Women's Health Service Line will continue its support and participation in the development and implementation of local and state public health department programs, maternal health committees and a women's health task force, such as the Georgia Perinatal Quality Collaborative led by the Georgia Department of Public Health, which launched two state-wide initiatives to address the top causes of pregnancy-related deaths in the state. Participation in these and other collective efforts will continue to address health disparity and equity challenges that impact health outcomes for Georgia's mothers and infants.

Programmatic Productivity
Number of perinatal support services, family education and breastfeeding support education classes
Number of participants in perinatal support services, family education and breastfeeding support education classes
Number of committees WellStar Women's Health participates in and the results (e.g., state-wide initiatives, etc.)
Number of women receiving educational materials during prenatal visits

Programmatic Outcomes
Improved outcomes, as measured by quality indicators, in cases of maternal obstetric hemorrhage and hypertensive crisis
Number of mothers screened and referred to behavioral health service for postpartum depression
Maternal and child health public policy that WellStar informs on behalf of women in Georgia
Percentage of breastfeeding class participants that uptake breastfeeding
Percentage of participants that recommend future perinatal support services, family education and breastfeeding support classes to others
Percentage of participants that reported an increase in knowledge, skills and abilities after completing perinatal support services, family education and breastfeeding support classes
Participant satisfaction score

23 *O'Connor E, Senger CA, Henninger ML, Coppola E, Gaynes BN. Interventions to Prevent Perinatal Depression: Evidence Report and Systematic Review for the U.S. Preventive Services Task Force. JAMA. 2019;321(6):588–601. doi:10.1001/jama.2018.20865*

Community-Driven Solutions:

Cancer Prevention and Screening

Cancer is the second leading cause of death in Georgia and can be caused by many things, including exposure to cancer-causing substances, certain behaviors, age, and inherited genetic mutations.[24, 25] According to the Georgia Department of Health's Georgia Cancer Control Consortium (GC3), cancer continues to remain as one of the top causes of death in our state. While the burden of cancer is shared by all Georgians, several disparities exist:[26]

- Cancer incidence and mortality is disproportionately greater among men and among minority and medically underserved populations.
- Black men in Georgia are 14 percent more likely to be diagnosed with cancer and 31 percent more likely to die from the disease than white men.
- Black men are almost three times more likely to die from prostate cancer than white men.
- While white women have a higher incidence of breast cancer than black women, black women are more likely to die of breast cancer.
- Black men and black women have a higher incidence of colorectal cancer and higher mortality rates from colorectal cancer than white men and white women.
- Men living in rural areas are more likely to die from lung cancer than men in more urban parts of the state which follows.

These disparities may be explained by patterns of screening, access to care, poverty patterns of tobacco use and the absence of protections from secondhand smoke. Based on current evidence, screening for breast, colorectal and lung cancers in appropriate populations by age and/or genetic risk can over time:[27]

- Increase a patient's knowledge and understanding of the importance of screening
- Increase the number of early-stage cancer detection
- Decrease the number of late-stage cancers detected
- Decrease the number of deaths from cancer

24 *National Cancer Institute (2019). Research on Causes of Cancer. Retrieved from: https://www.cancer.gov/research/areas/causes*

25 *Centers for Disease Control and Prevention (2017). Stats of the States of Georgia. Retrieved from: https://www.cdc.gov/nchs/pressroom/states/georgia/georgia.htm*

26 *Georgia's Cancer Prevention and Control Priorities. Retrieved from: ftp://ftp.cdc.gov/pub/Publications/Cancer/ccc/georgia_ccc_plan.pdf*

27 *National Cancer Institute Cancer Screening Overview. Retrieved from https://www.cancer.gov/about-cancer/screening/patient-screening-overview-pdq#_17*

Despite the known benefits, cancer screening rates continue to be a challenge throughout the state with minority, low income and rural populations reporting less screening according to recommended guidelines. To address the cancer disparities and increase cancer screening rates across WellStar communities, WellStar is committed to dedicating resources to address these critical gaps. WellStar aims to grow the preventative screening for cancers and increase the current screening by a minimum of 20 percent. WellStar will build a program that supports the patients and physicians through the screening and navigation process with an extended care model that ensures that care is continuous and well-coordinated. This aligns with US Preventive Services Task Force recommendations, Centers for Disease Control and Prevention, American Cancer Society guidelines and Georgia's Cancer Prevention and Control priorities to increase access to the appropriate cancer screening to detect the disease early and prevent morbidity and premature mortality.[25, 28, 29, 30]

Programmatic Productivity
Create the ideal proactive, preventative cancer screening program to support the communities WellStar serves
Create a cancer prevention program that supports the physicians through the screening and navigation process with an extended care model
Number of community cancer prevention screenings by cancer types
Number of participants screened through cancer screening initiatives by cancer types

Programmatic Outcomes
Reduction in advanced cancer cases
Number of participants with positive findings at screening programs that are referred follow-up with appropriate healthcare professionals
Percentage of screened participants that reported an increase in knowledge, skills and abilities after completing cancer prevention screening
Patient satisfaction score

28 *American Cancer Society Prevention and Early Detection Guidelines. Retrieved from https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines.html*

29 *US Preventive Services Task Force A and B Recommendations. Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/*

30 *Centers for Disease Control and Prevention (2018). Reducing Health Disparities in Cance. Retrieved from https://www.cdc.gov/cancer/healthdisparities/basic_info/disparities.htm*

Building a Sustainable Infrastructure:

Screening for Food Insecurity

Food insecurity is an important but often overlooked factor affecting the health of a significant segment of the American population. Poor nutrition is one of the leading causes of the obesity epidemic. The 2019 CHNA revealed that many of WellStar's communities are in the vicious cycle of balancing their housing and healthcare needs with their food needs and the constant sacrifices and trade-offs that must be made to maintain their livelihoods. Individuals and families who lack consistent access to enough healthy food may have a higher risk of developing chronic diseases like obesity, hypertension and diabetes. Food insecurity can also make management of these and other health conditions more challenging.

In 2017, 11.8 percent of households (15 million) in the United States had difficulty at some time during the year providing enough food for all their members due to a lack of resources.[31] There is evidence that efforts to increase access to healthy nutrition in communities has:[32]

- Strengthened local and regional food systems
- Increased access to fruits and vegetables
- Increased fruit and vegetable consumption in low-income communities, including among children and diabetics
- Improved dietary choices; and prevented and reduced obesity

To address this social determinant of health, WellStar Health System will begin incorporating food insecurity screening as a standardized protocol into existing patient intake procedures, a practice recommended by numerous professional societies, including the American Academy of Pediatrics and the American Diabetes Association.[31, 32]

31 *Household food security in the United States in 2017. U.S. Department of Agriculture. Coleman-Jensen, A., Rabbitt, M. P., Gregory, C. A., & Singh, A. (2018, September). Available at https://www.ers.usda.gov/webdocs/publications/90023/err256_summary.pdf?v=0*

32 *Nutrition prescriptions (2018). County Health Rankings and Roadmaps, What works for Health. Retrieved from http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/nutrition-prescriptions*

In addition, screening for food insecurity is appropriate and warranted in the clinical setting, especially in environments where a significant percentage of the patient population has been identified as low income.[33] Food insecurity screening quickly identifies households at risk for food insecurity, enabling providers to target services and treatment plans that address the health and developmental consequences of food insecurity. Research has found that screening for food insecurity can:[34, 35, 36]

- Connect families to sustainable food access support
- Identify underlying barriers to health conditions, misuse of Emergency Departments and medication adherence
- Improve patient satisfaction scores
- Help reduce the prevalence of food insecurity and its effects on the community

Programmatic Productivity
Identify patients living in food-insecure households while they are in the healthcare setting
Refer those patients and their families to food bank agencies and programs to connect patients with healthy food access as well as application assistance for SNAP and other long-term supports
Create new food distribution programs in the healthcare facility when there is sufficient need and interest, and/or existing community resources are insufficient

Programmatic Outcomes
Hospital readmissions rates for intervention population
Patient satisfaction scores for intervention population
Number of patient referrals to community resources that address food access

33 *Promoting Food Security for All Children (2015). Retrieved from http://pediatrics.aappublications.org/content/136/5/e1431*

34 *Lane, W. G., Dubowitz, H., Feigelman, S., & Poole, G. (2014). The Effectiveness of Food Insecurity Screening in Pediatric Primary Care. International journal of child health and nutrition, 3(3), 130–138. doi:10.6000/1929-4247.2014.03.03.3*

35 *Marpadga, S., Fernandez, A., Leung, J., Tang, A., Seligman, H., & Murphy, E. J. (2019). Challenges and Successes with Food Resource Referrals for Food-Insecure Patients with Diabetes. The Permanente journal, 23, 18-097. doi:10.7812/TPP/18-097*

36 *Health Care Without Harm (2018). Delivering Community Benefit Healthy Food Playbook. Retrieved from https://foodcommunitybenefit.noharm.org/resources/implementation-strategy/food-insecurity-screening*

Building a Sustainable Infrastructure:

Hospital's Roles and Responsibilities

Although the majority of WellStar's community benefit services are delivered systemwide, each of WellStar's 11 not-for-profit hospitals plays a role in addressing the priority health needs identified from its CHNA. Hospital presidents and community benefit liaisons are vital to tracking and assisting in the implementation of WellStar's community benefit programs.

To accomplish this, WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals will build a sustainable and outcomes-driven community benefit program that demonstrates commitment to community health improvement and health equity. Through dedicated leadership, accountability, collaborative partnerships and stewardship of fiscal and human resources, we will create a more healthy community through outreach, education and advocacy focused on priority health needs.

Programmatic Productivity
Identify a community benefit liaison for each hospital
Track and report community benefit activities in the Community Benefit Inventory for Social Accountability (CBISA — community benefit software) and via Community Benefit 101 training
Create and promote an inventory of hospital services, activities and resources that are currently addressing social determinants of health
Assist with government-sponsored health insurance enrollment and applications for WellStar's Financial Assistance Program and promote awareness on-site at the hospital

Programmatic Outcomes
Increased patient referrals to community resources that address social determinants of health and needed resources
Increased CBISA utilization to more accurately report community benefit investment
Increased primary care access through care coordination with community health clinics

Building a Sustainable Infrastructure:

Public Policy and Advocacy

WellStar's leadership and the Government Relations team interacts with various state agencies responsible for community health needs, regulation and planning, such as the Department of Community Health, the Department of Public Health and the Department of Behavioral Health and Developmental Disabilities. WellStar proactively educates and engages policymakers on the health system's mission, concerns and legislative priorities, which include but are not limited to preservation of Certificate of Need, enhanced levels of Medicaid coverage and reimbursement, access to affordable and high quality coverage and care, addressing social determinants of health and ensuring resources are readily available to treat behavioral health and substance abuse. WellStar Health System's commitment to work jointly with various levels of government, community clinics, community organizations, chambers of commerce and industry coalitions strengthens our ability to effect real change and foster communities of improved health and wellness for the betterment of all Georgians.

Building a Sustainable Infrastructure:

WellStar Research Institute

At WellStar, we believe that a successful clinical research program benefits our patients, physicians and community. WellStar Research Institute (WRI) is the centralized research facility serving WellStar Health System that strives to push the boundaries of current knowledge to uncover new ways to fight disease and keep people healthy. Through research, WRI offers cutting-edge therapies and contributes to the advancement of medical and social behavior science. This helps inform WellStar providers' understanding of the needs of patients, the healthcare industry and society at large.

Health Needs Not Addressed

Health needs not identified as priority to the hospitals fall into one of three categories:

1. Beyond the scope of WellStar services
2. Needs further intervention, but no plans for expanding current community benefit services at this time
3. Relying on community partners to lead efforts with expertise in these areas with WellStar in a supportive role

Evaluation of Action

At WellStar Health System our success is measured by our ability to:[37]

- Reduce health disparities by increasing care access and support services to under-resourced, at-risk community members
- Strengthen community capacity and collaboration for shared responsibility to address the priority health needs of the community the hospitals serve

In addition, did WellStar's Community Benefit initiatives:

- Improve the overall health of the community through improved access to care and a reduction of the incidence and prevalence of chronic disease?
- Serve and advocate for the medically underserved and under-resourced populations with the goal of providing "the right care at the right place?"
- Improve the delivery and reporting of community benefit services to better demonstrate WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals' commitment to improve overall community health?
- Implement improved financial assistance, billing and collection policies that protect patients and reduce the number of patients relying on charity care?
- Collaborate with multi-sector community partners to relieve or reduce the burden of government?

Next Steps[38]

To inform strategic action plans and strategically align our community benefit initiatives with the needs of our communities, WellStar Health System will:

1. Build consensus around an evaluation plan
2. Decide what goals are most important to evaluate
3. Determine evaluation methods
4. Evaluate current partnerships and create new health need focused alignment
5. Identify indicators and how to collect data (process and evaluation measures)
6. Identify benchmarks for success
7. Establish data collection and analysis systems
8. Collect credible data
9. Monitor progress toward achieving benchmarks
10. Review evaluation results and adjust programs
11. Share results at WellStar Community Health Collaborative task force meetings and, as needed, with the community

37 Public Health Institute, Kevin Barnett. Quality and Stewardship in Community Benefit, March 11, 2010.

38 County Health Rankings and Roadmaps/Evaluate Actions. http://www.countyhealthrankings.org/roadmaps/action-center/evaluate-actions

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